BYLAWS
OF THE MEDICAL STAFF
OF

Southlake Specialty Hospital, LLC d/b/a
Texas Health
Harris Methodist Hospital
Southlake

Revised and Adopted: March 19, 2018

Approved by the Medical Staff and Board of Managers

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DEFINITIONS

The words and phrases herein have the following meanings whenever used in these Bylaws, unless the context requires otherwise.

Administration: Refers to the Hospital President or the Hospital President's designee, who is responsible for managing the day-to-day operations of the Hospital.

Admitting Privileges: The right of members of the Medical Staff to admit their patients to the hospital.

Allied Health Professionals (AHP): Individuals, other than a licensed physician, dentist, or podiatrist, who exercise independent judgment within the areas of his or her professional competence and the limits established by the Board of Managers, the Medical Staff, and the applicable State Practice Acts; or who is qualified to render direct or indirect care or assistance under the supervision or direction of a medical staff member possessing privileges and prerogatives in conformance with the rules adopted by the Board of Managers, these Bylaws, and the Medical Staff Rules and Regulations. AHP's are not eligible for medical staff membership.

Attending Physician: The Medical Staff member who is the physician of record for a given patient.

Appointment and Reappointment: The process specified herein by which a Practitioner acquires and retains Medical Staff membership and delineated clinical privileges.

Board of Managers: The governing body of Southlake Specialty Hospital, LLC d/b/a Texas Health Harris Methodist Hospital Southlake.

Bylaws: The Medical Staff Bylaws of Southlake Specialty Hospital, LLC d/b/a Texas Health Harris Methodist Hospital Southlake.

Chief of Staff: A member of the active medical staff who is elected in accordance with these bylaws to serve as chief officer of the medical staff of this hospital.

Clinical privileges: The permission granted to a physician, podiatrist, oral surgeon or dentist as recommended by the Medical Staff and approved by the Board of Managers to provide specific professional, diagnostic, therapeutic, medical, dental, or surgical services and procedures at the Hospital.

Completed Application: An application, either for initial appointment or reappointment to the medical staff or for clinical privileges, that has been determined by the applicable medical staff department(s), Credentials Committee, Medical Executive Committee and the Board of Managers to meet the requirements of the medical staff bylaws, rules and regulations.

Day: Calendar day.

Delegating/sponsoring physician means a member of the Medical Staff of the Hospital who delegates the performance of medical acts, supervises and/or directs an Allied Health Professional (AHP) and/or Advanced Practice Professional (APP) by virtue of law, Hospital policy, and/or terms of the AHP's/APP's appointment to practice in the Hospital. A Delegating Medical Staff Member shall not supervise/delegate any procedure or patient care service that the Delegating Medical Staff Member is not duly authorized by the Hospital to perform. An AHP/APP may receive delegation from more than one Delegating Medical Staff Member.

Dentist: An individual who has received a doctor of dental surgery or a doctor of dental medicine degree and has a current, unrestricted license to practice dentistry in this state.

Emergency service call coverage means emergency call coverage for the Hospital as a whole. It is not limited to the Emergency Department, but also includes such obligations as imposed by law including The Emergence Medical Treatment and Labor Act and any successor provisions.

Encounter means a Practitioner-to-patient encounter, or a consultant-to-Practitioner encounter, from which it is possible to make a meaningful evaluation of the Member's clinical experience, competence and care of the patient. The encounter must occur in the Hospital, or the Member shall have the burden to present sufficient evidence of an encounter that occurred in another clinical setting.

Ex Officio: One who serves as a resource person by virtue of an office or position held, but without voting privileges.

He or His: Used in these Bylaws refers to both genders. The use of a masculine pronoun is not intended to express an opinion about the gender of the Practitioners governed by these Bylaws.

Hospital President: The individual designated by the Board of Managers to manage the day to day operations of Southlake Specialty Hospital, LLC d/b/a Texas Health Harris Methodist Hospital Southlake.

HIPAA Privacy Regulations: The federal privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996.

Hospital: Southlake Specialty Hospital, LLC d/b/a Texas Health Harris Methodist Hospital Southlake.

Licensed Independent Practitioners: Licensed independent practitioners provide medical care to patients, in accordance with state licensure laws, without supervision by a physician.

Medical Director: The head of a clinical department.

Medical Staff: The formal organization that consists of all physicians (M.D. or D.O.), dentists, and podiatrists who hold an unrestricted license in this state and who are privileged to provide patient care services in this hospital within the scope of their licensure and approved clinical privileges.

Medical Staff Member or Member: Unless otherwise stated, a fully licensed Practitioner who is appointed by the Board of Managers as a Member of the Medical Staff of Hospital.

Physician means

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery in the State of Texas;
2. A doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State of Texas who is acting within the scope of his license when he performs such functions; or
3. A doctor of podiatric medicine, but only with respect to functions that he is legally authorized to perform by the State of Texas.

Podiatrist means a doctor of podiatric medicine; Podiatrists are limited to performing functions that they are legally authorized to perform by the State of Texas.

Practitioner means any individual who is a graduate of an approved medical, dental, or podiatry school and holds a current, valid license to practice medicine, podiatry, or dentistry in the State of Texas.

President means the individual designated by the Board of Managers to manage the performance of the Hospital.

Professional review action means an action or recommendation of a professional review body that is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual Practitioner (whose conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. An action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on:

1. The physician's association, or lack of association, with a professional society or association
2. The physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business
3. The physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services, whether on a fee-for-service or other basis
4. A physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with a member or members of a particular class of health care Practitioner or professional
5. Any other matter that does not relate to the competence or professional conduct of a physician

Professional review activity means activities undertaken in determining whether a Practitioner may be appointed and/or be granted clinical privileges in this Hospital, determining the scope or

conditions of such clinical privileges or membership, or changing or modifying such clinical privileges or membership.

Professional review body means this Hospital and the Governing Board, or any committee of the Hospital and/or Medical Staff, which conducts professional review activities.

Registered active candidate means a Practitioner registered and in the process of obtaining his board certification.

Rules and Regulations: The Rules and Regulations of the Medical Staff at Southlake Specialty Hospital, LLC d/b/a Texas Health Harris Methodist Hospital Southlake.

Specialty: A division of the Medical Staff composed of Members who practice a similar specialty.

State means Texas.

Telemedicine means the practice of medical care initiated by a distant site provider, who is physically located at a site other than the site where the patient is located, for the purposes of evaluation, diagnosis, consultation, or treatment which requires the use of advanced telecommunications technology.

Year means twelve (12) consecutive months.

ARTICLE I APPOINTMENT AND REAPPOINTMENT

1.1 General

Except as otherwise specified herein, no Practitioner (including those engaged in administrative positions) shall exercise clinical privileges in the Hospital unless and until the Practitioner applies for and receives appointment to the Medical Staff in accordance with these Bylaws. Appointment to the Medical Staff shall confer on the Practitioner only such clinical privileges as have been granted in accordance with these Bylaws. Those categories of Practitioners who are eligible for appointment to the Medical Staff shall be determined by the Board of Mangers.

1.2 Burden of Producing Information

1.2.1 Burden of Production:

The Practitioner has the burden of producing in a timely fashion all information supporting the Practitioner's qualifications and suitability for the clinical privileges and Medical Staff category requested and resolving any doubts about these matters. Any application for appointment, reappointment, change in category, or change in clinical privileges shall be deemed complete only when the Hospital and Medical Staff, including any committees, have received all information required to be produced or otherwise requested from the Practitioner.

1.2.2 Failure to Meet Burden of Production:

The Practitioner's failure to sustain this burden within the time frame specified by the Medical Staff Services office, Credentials Committee, or Medical Executive Committee (MEC) shall result in the immediate withdrawal of the application without further processing or consideration. The withdrawal of the application shall be automatic upon expiration of the time frame specified, shall not require further action by the Credentials Committee or MEC, and shall not be considered a professional review action under these Bylaws.

1.2.3 False Information:

Submission of any false information on the application for appointment or reappointment for Medical Staff membership and privileges may, as determined by the MEC, result in the immediate withdrawal of the application without further processing or consideration, and may, as determined by the MEC, thereafter disqualify the Practitioner from Medical Staff membership or reapplication at any time in the future. Additionally, the MEC may take any other action as allowable under law or these Bylaws that the MEC may determine, in its sole discretion, to be appropriate. Submission of false information includes the omission of materially true information or submission of untrue information.

1.3 Appointment Authority

The Board of Managers retains the ultimate authority in deciding all Medical Staff appointments and reappointments based on the recommendations of the MEC and other committees involved in credentialing and privileging.

1.4 Term of Appointment

Initial appointment to the Medical Staff shall be for any period of time up to twenty-four months (24) as determined by the Board of Managers. Term of reappointment is governed by Section 1.10-1.

1.5 Intentionally Omitted

1.6 Application for Initial Appointment

a. Provided the Practitioner meets the minimum eligibility requirements, the Practitioner upon request shall receive an application packet with instructions for completing the application, notification of supporting documents needed, and copies of these Bylaws, Rules and Regulations and other applicable policies of the Medical Staff relating to clinical practice in the Hospital. The Practitioner shall submit a completed and signed application on the prescribed form (or accompanied by an explanation of why answers are unavailable) with a non-refundable application fee as specified by the Hospital.

b The following documentation is necessary to complete an application. It is the applicant's responsibility to provide:

1. Completion of all blanks on the application form with necessary additional explanations and indication of privileges requested;

2. A copy of current Texas state license and, where applicable, Drug Enforcement Agency (DEA) and Texas Department of Public Safety registration certificates.

3. A copy of the declaration page of current professional liability insurance policy showing proof of coverage, in the minimum amounts of $200,000 per occurrence and $600,000 aggregate, or as otherwise established by the Board of Managers.

4. Copies of certificates or letters confirming completion of an approved residency/training program or other educational curriculum;

5. Physicians, oral surgeons, and podiatrists must provide a profile of professional activity from the current hospital or facility of main affiliation for the last two (2) years, or residency training logs if a recent graduate, documenting the applicant's clinical work. In the event the applicant is unable to document appropriate hospital/facility activity as outlined above, the applicant shall provide documentation sufficient to explain the lack of requisite hospital/facility activity

as well as documentation of current clinical competence;

Dentists without hospital experience shall submit a list of cases documenting their clinical experience and procedures performed for the last two (2) years, or training logs if a recent graduate;

6. Completed and signed authorization to conduct a criminal background check;

7. Current, valid identification photograph; and

8. Any and all other forms that constitute an application packet as well as all other documentation which may be requested.

1.6.1 Minimum Eligibility Criteria

Each Practitioner must meet the following minimum eligibility criteria for the requested Medical Staff category and shall provide competent evidence of same:

a. *Education*. Each Practitioner seeking membership to the Medical Staff shall be a graduate of a professional school approved by a nationally or internationally recognized accrediting body and by the Texas Medical Board, Council on Podiatric Medical Education of the American Podiatric Medical Association, or the Commission on Dental Accreditation of the American Dental Association. At the time of the initial application, the Practitioner shall have satisfactorily completed a residency program (with the exception of General Dentistry) accredited by one of the following:

- American Council for Graduate Medical Education
- American Osteopathic Association
- Commission on Dental Accreditation of the American Dental Association
- Council on Podiatric Medical Education

b. *Board certification*

1. All Practitioners seeking clinical privileges and membership to the Medical Staff shall be certified or shall be an registered active candidate within their practice specialty by one of the following specialty boards, or another board acceptable to the Governing Body:

- American Board of Medical Specialties
- American Osteopathic Association
- Royal College of Physicians and Surgeons of Canada
- American Board of General Dentistry, American Board of Dental Public Health, or American Board of Pediatric Dentistry
- American Board of Oral and Maxillofacial Surgery
- American Board of Foot and Ankle Surgery
- American Board of Podiatric Medicine
- American Board of Multiple Specialties in Podiatry

Notwithstanding this requirement, a Practitioner who is not board certified at the time of initial appointment must obtain certification no later than the time of application for reappointment following the seventh year after completion of training. A failure to secure such board certification shall render the applicant ineligible for reappointment. Three failures to successfully pass all parts of the board certification exam during the seven (7) years following completion of training shall render the applicant ineligible for initial appointment or reappointment.

2. Practitioners who practice within a subspecialty shall be certified in such subspecialty to the extent such certification exists and meets the requirements of 1.6.1.b. If so certified in a subspecialty, Practitioners shall maintain such subspecialty certification. Subspecialty certification will satisfy the general board certification requirement of these Bylaws.

3. Except as otherwise provided in these Bylaws, all Practitioners are required to maintain board certification throughout their membership on the Medical Staff. Practitioners must obtain recertification or meet Maintenance of Certification requirements in the time frame required from the specialty board if recertification or Maintenance of Certification is required by the appropriate specialty board. Unless otherwise provided herein, failure by the Practitioner to maintain board certification as required in this section shall result in the automatic resignation of a Practitioner's Medical Staff clinical privileges at the next reappointment unless a waiver is requested and granted. A Practitioner whose privileges are deemed resigned for failing to maintain board certification is not entitled to a hearing under these Bylaws, and such resignation shall not be considered a professional review action.

c. *Licensure*. The Practitioner shall be in the process of applying for or hold a current valid and unrestricted license to practice in the State of Texas (or in the case of telemedicine, a current valid and unrestricted Texas license to practice out-of-state telemedicine) and document that no current or past license from any state has ever been suspended for more than thirty (30) days or revoked.

In the case of visiting Practitioners, they shall meet all the licensure obligations as established by the Texas Medical Board.

If required for clinical practice, each Practitioner seeking membership in the Medical Staff shall maintain a current valid and unrestricted controlled substances certificate with the Federal Drug Enforcement Administration (DEA) and registration with the Texas Department of Public Safety (DPS).

d. *Insurance*. All Practitioners seeking membership in the Medical Staff shall have and maintain at all times professional medical liability insurance that is currently in force with a minimum limit of $200,000 per occurrence and $600,000 in the aggregate and that does not exclude from coverage any of the procedures for which the Practitioner is seeking clinical privileges. Professional medical liability insurance is not required for Active Community Staff or Administrative Staff who do not have clinical duties or responsibilities at the Hospital.

e. *Privilege card*. Each Practitioner shall also meet the specific eligibility requirements for requested privileges as delineated on the applicable privilege card(s).

f. The applicant must not be the subject of an integrity or compliance agreement with any federal or state entity.

g. The applicant must not be subject to any exclusions or limitations imposed by any state or federal health care program, including but not limited to Medicare or Medicaid.

h. The applicant must take and pass such random drug screening exams as may be required.

i. Each Practitioner shall also meet the specific eligibility requirement for requested privileges as delineated on the applicable privilege card(s).

1.6.2. Waiver

One or more of the eligibility requirements in Section 1.6.1.a. or 1.6.1.b. may be waived by the Governing Board, in its sole discretion. The Governing Board may consider, among other things, whether the best interests of the Medical Staff or Hospital or patient care needs will be served by granting Medical Staff membership to a Practitioner whose ineligibility is due only to these requirements, and may, in its sole discretion, require specialty-specific competency evaluation in determining whether to grant such a waiver. A waiver under this section is not available for the granting of temporary privileges for a limited duration, as provided in these Bylaws. A failure to grant a waiver does not entitle the Practitioner to any hearing rights under these Bylaws.

1.6.3. Additional Required Information

As part of the credentialing process, the Practitioner shall disclose the following information, which will be considered in determining suitability of the Practitioner for admission to the Medical Staff:

a. Any voluntary or involuntary restriction, abatement, reduction, suspension, relinquishment, lapse, denial, revocation, and/or investigations of the Practitioner's license to practice in any state or locality, along with any orders or remedial plans issued by any licensing authority.

b. Any voluntary or involuntary restriction, abatement, reduction, suspension, relinquishment, lapse, denial, or revocation of the Practitioner's DEA certificate or DPS registration, as well as any investigations related to such certificate or registration.

c. Any voluntary or involuntary restriction, abatement, reduction, suspension, relinquishment, lapse, denial, revocation, and/or investigations by a health care entity of the Practitioner's Medical Staff membership or clinical privileges at any facility that grants membership and privileges.

d. Any disciplinary action or investigation that resulted in corrective action by a health care entity.

e. Any denied membership application or renewal, or any disciplinary action taken against the Practitioner, by any medical organization including but not limited to physician-hospital organizations (PHO) and accountable care organizations (ACO).

f. Any investigations, sanctions, exclusions, or limitations imposed by the Texas Medical Foundation or any other professional review organization.

g. Any investigations, sanctions, exclusions, or limitations imposed by any state or federal entity or state or federal health care program, including but not limited to Medicare or Medicaid.

h. Any investigations, sanctions, exclusions, or limitations imposed by any private health care program, including but not limited to private third-party insurers, health maintenance organizations, physician-hospital organizations (PHO), and accountable care organizations (ACO).

i. Any arrest or filing of criminal charges against the Practitioner.

j. Any professional liability cases filed, currently pending, or final judgments or settlements that have been made against, or entered by, the Practitioner.

k. Requested membership category, department(s), and clinical privileges.

l. Information confirming health status.

m. List of health care facilities or organizations where the Practitioner currently holds or has at any time held membership and clinical privileges.

n. Unless otherwise approved by the Credentials Committee, three (3) references from unrelated individuals who can attest to the Practitioner's professional qualifications, clinical competency, behavior, and conduct within the past two (2) years relating to the Practitioner's specialty. These individuals may not currently be in practice with the Practitioner and may not have a current or known future financial relationship with the Practitioner. The Credentials Committee in its discretion may accept references from individuals in a group practice (defined as a practice with five (5) or more physician members) with the Practitioner if it determines that there is no direct financial relationship between the Practitioner and the reference that would affect the reference. Practitioners finishing training programs shall provide one (1) reference from the program director of each program, whether completed or not, whether internships, residency programs, fellowship programs, or all, as well as two (2) other references from individuals who are knowledgeable about the Practitioner's professional performance and conduct within the past two (2) years.

o. Any periods of time in excess of sixty (60) days that the Practitioner has not been in continuous active practice or residency.

p. Affirmation and evidence that the Practitioner has established or will establish an office within a reasonable distance and/or time frame of the Hospital in keeping with the nature and extent of privileges being sought, or as required by the Medical Staff Rules and Regulations or by the appropriate clinical department, to allow for a timely response to patient needs and to provide appropriate continuity of care. Applicants for Telemedicine Staff privileges are exempt from the requirements of this subsection.

q. Current cell phone number and e-mail address.

r. Documentation of compliance with the Hospital's vaccination policy.

s. Documentation of TB skin test or documentation of chest x-ray as appropriate upon initial application and reappointment.

t. Documentation of training on the Hospital electronic health record system as may be available prior to admission to the Medical Staff.

u. Documentation of successful completion of Hospital orientation, as may be available prior to admission to the Medical Staff.

v. Affirmation that the Practitioner:

1. Has never been limited in any way by a physical problem that currently affects clinical practice.

2. Has never been limited in any way at any time by any mental, alcohol, drug, or substance problems.

3. Has never been placed or asked to be placed under a clinical, behavior, monitoring, rehabilitation, or other type of contract, agreement, or understanding (whether in writing or not, whether disciplinary or not) related to alcohol, drug, or substance abuse or behavior, mental, emotional, or physical issues.

4. Has never received any type of treatment for drug, alcohol, or substance abuse.

w. Such other information as may be requested.

1.6.4 Initial Review of Applications

As a preliminary step, the Credentials Committee and/or its designee, which includes the Medical Staff Services office, shall determine whether the Practitioner satisfies all the minimum eligibility criteria for Medical Staff membership. If the Practitioner fails to meet the minimum eligibility criteria, the Practitioner shall be notified in writing within 30 days of the determination of ineligibility and the reasons for such ineligibility. The application shall be deemed withdrawn immediately due to ineligibility without further processing or consideration. Failure to meet the

minimum eligibility criteria does not entitle a Practitioner to the right to a hearing under these Bylaws.

1.7 Effect of Application

By applying for appointment to the Medical Staff, each Practitioner:

a. Agrees to appear for interviews as requested by any committee of the Medical Staff and Hospital.

b. Agrees to participate in an orientation for new Practitioners as part of the initial appointment process.

c. Agrees to participate in electronic health record system training and to remain proficient in the use of the electronic health record system throughout any appointment period.

d. Authorizes and agrees to execute all documents necessary to allow the Credentials Committee, the MEC, and the Governing Board, and/or their designees, which include the Medical Staff Services office, to contact individuals and organizations who have been associated with the Practitioner and who may have information bearing on the Practitioner's current competence, qualifications, and performance, and authorizes such individuals and organizations to candidly provide all such information in both oral and written forms.

e. Consents and agrees to execute all documents necessary to allow inspection, by the Credentials Committee, MEC, or the Governing Board and/or their designees, which include the Medical Staff Services office, of records and documents, including medical, substance abuse, mental health, and therapy records, relevant to an evaluation of the Practitioner's qualifications and ability to perform the requested clinical privileges, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying.

f. Agrees to sign applicable documents releasing from any liability, to the fullest extent permitted by law, all persons and entities involved in the credentialing process for their acts performed in connection with investigating and evaluating, determining, recommending, and/or deciding on the granting of Medical Staff membership and clinical privileges.

g. Consents to the full disclosure of any information regarding the Practitioner's professional, disciplinary, or ethical standing that the Hospital or Medical Staff or any committee thereof may have to other Hospitals, health care entities, medical associations, licensing boards, local, state, or federal entities, third-party payors, and other similar organizations and releases all those involved in the gathering and release of such information from liability for so doing to the fullest extent permitted by law.

h. Consents to the release to any other facility any and all information relating to any investigation of the Practitioner , as well as any and all information relating to membership and privileges including any denial, revocation or restriction of same.

i. Agrees that in the event clinical privileges are granted, the Practitioner will not exercise such privileges until he has completed a Hospital orientation program and has received such training with the Hospital's electronic health record system as deemed necessary by the Hospital and/or MEC.

1.8 Procedure for Approval of Application

1.8.1 Review and Verification of Information

The Credentials Committee or its designee, which includes the Medical Staff Services office, shall assess whether the Practitioner meets all the qualifications for Medical Staff membership by verifying, to the best of its ability, the accuracy and veracity of the information submitted by the Practitioner and collect additional information including but not limited to the following:

a. *Current licensure*. Document and verify from primary sources the Practitioner's current licensure status.

b. *Relevant education, training and experience*. Document and verify from primary sources whenever feasible the veracity of the Practitioner's disclosures regarding relevant education, training and experience; query the National Practitioner Data Bank; confirm board certification or registered active candidate status from the applicable specialty board.

Continuing professional competence. Confirm and document compliance with Section 1.6.3 (n).

c *Health status*. Affirm the absence of any history of alcohol or substance abuse or any physical or mental health conditions from the director of the residency and fellowship program, or by the chief of service or staff at another hospital where the Practitioner has privileges, or by a currently licensed physician designated by the Credentials Committee. Such confirmation may include a physical and/or mental health examination or assessment conducted by a health care professional chosen by the Credentials Committee or the Practitioner Behavior and Health Committee of the Medical Staff. Such examination shall be at the Practitioner's expense. Practitioner shall execute all authorizations as may be necessary to perform this review.

d *Litigation history*. Verification of the existence of any prior or current lawsuits, settlements, or judgments, including malpractice claims.

The Credentials Committee shall have up to four (4) months following receipt of an application to complete the verification and review functions described herein in order to determine whether or not the application is complete. If after four (4) months all necessary information has not been

received from the Practitioner or other sources, and/or all questions regarding the Practitioner or other sources have not been satisfactorily answered, the application may be deemed incomplete and immediately withdrawn without further processing or consideration. In such event, the Practitioner shall not be entitled to the right to a hearing under these Bylaws.

1.8.2 Hospital Needs and Resources

Clinical privileges in connection with appointment, reappointment or otherwise may be declined on the basis of:

a. an inability to provide adequate facilities or support services for a service line or for the Practitioner and such Practitioner's patients.

b the existence of a contractual or other arrangement for the provision by Practitioners of professional services of the type being requested.

c changes in the law.

d a determination that privileges requested are for services, treatment or procedures the Board of Managers has determined will not be offered by the Hospital.

e. a determination that the privileges requested are beyond the scope of practice of the Practitioner's discipline as defined by law.

f. a determination that additional Practitioners for a particular discipline and/or appointment category are not necessary for the provision of services, treatment , or procedures to patients.

Declining to offer clinical privileges under this Section shall not constitute a denial of clinical privileges and shall not entitle the Practitioner to the right to a hearing under these Bylaws.

1.8.3 Application Review

Upon a determination that an application is complete, the application and all supporting documentation shall be forwarded to the Credentials Committee, for the purpose of reviewing the application.

1.8.4 Credentials Committee Recommendation

Not later than 90 days after receiving a completed application the Credentials Committee shall make its recommendation. During such time, the Credentials Committee or its designee including the Medical Staff Services Office, may interview the Practitioner, seek additional information from the Practitioner and/or request further review or input as it deems appropriate. It may contact other persons or entities with knowledge of the Practitioner's qualifications. The time frame for acting upon a completed application shall be extended by the number of days required to obtain such additional information. After reviewing all pertinent information, the

Credentials Committee shall make a recommendation to the MEC regarding appointment and clinical privileges to be granted, along with any special conditions.

1.8.5 MEC Recommendation

Upon receiving the recommendation from the Credentials Committee, or its designee, including the Medical Staff Services Office, the MEC may interview the Practitioner, seek additional information from the Practitioner, and/or request further review or input as it deems appropriate. It may contact other persons or entities with knowledge of the Practitioner's qualifications. The time frame for acting upon a completed application shall be extended by the number of days required to obtain such additional information. After reviewing all pertinent information, the MEC shall make a recommendation to the Board of Managers regarding appointment and clinical privileges to be granted, along with any special conditions.

1.8.6 Board of Managers Action

a. The Board of Managers shall approve or deny the application not later than 60 days after receiving the MEC recommendation. During such time, the Board of Managers may request further review or input as it deems appropriate before acting upon the application, as necessary. The Board of Managers may appoint a subcommittee comprised of the Chairman of the Board or his designee and 1 voting Board Member ("Board Subcommittee") to render a decision on behalf of the full Board in the case of (i) expedited processing under Section 1.9-2, or (ii) if the next regularly scheduled Board meeting would not be held within the time frame specified above.

b. If the action of the Board of Managers is favorable to the Practitioner, written notice shall be sent to the Practitioner regarding: (1) the Medical Staff category to which the Practitioner is appointed; (2) the clinical privileges granted; and (3) any special conditions attached to the appointment. Such notice shall be forwarded not later than 20 days following the action of the Board of Managers.

c. If the action of the Board of Managers is unfavorable to the Practitioner, written notice shall be forwarded to the Practitioner not later than 20 days following the action of the Board of Managers. The Practitioner shall be ineligible to reapply to the Medical Staff for the specific clinical privileges previously denied for a one (1) year period commencing upon the date of final resolution of the Practitioner's status (i.e. either the date of notice from Board of Managers if no hearing is requested, or the date of resolution of any hearing or subsequent appeals). Any reapplication after one (1) year shall be processed as a request for an initial appointment.

1.8.7 Previous Denied, Terminated or Withdrawn Applications

If an application for appointment or reappointment is tendered by a Practitioner who has been previously denied membership privileges; or who has had membership or privileges terminated due to lack of sufficient qualifications required to obtain and/or maintain membership or privileges; or whose prior application was deemed incomplete and withdrawn, and it appears that the application is based on substantially the same information as when previously denied, terminated or withdrawn, then the application shall be deemed insufficient, shall not be

processed further and shall be returned to the Practitioner. No right of hearing shall be available in connection with this section.

1.9 Special Provisions

1.9.1 Contracted Services

Practitioners applying for Medical Staff membership by virtue of a contractual relationship to provide clinical services at the Hospital are not entitled to the automatic granting of Medical Staff membership or clinical privileges by virtue of the contractual relationship. Such Practitioners shall follow the same procedures for requesting membership and clinical privileges as outlined in these Bylaws. Unless the contractual relationship between the Practitioner and the Hospital, or the Practitioner's group and the Hospital, states otherwise, the Practitioner's membership on the Medical Staff and any associated clinical privileges shall be deemed automatically terminated if the contractual relationship is terminated (either by termination of the contract, or termination of the Practitioner's association with the contracted group). In such event, the Practitioner shall have no right to a hearing under these Bylaws.

1.9.2 Expedited Process for Initial Appointment

In exceptional circumstances, an expedited processing of a particular application may be necessary to satisfy a demonstrated patient care or Hospital need. In such exceptional circumstances, the evaluation of an application on an expedited basis shall be performed pursuant to the following criteria. If the application is deemed incomplete, or if at any step of the approval process, a review is unfavorable to the Practitioner, the application may be sent through the customary application process and will no longer be eligible for expedited processing. All information on the application must be verified in accordance with these Bylaws before clinical privileges can be granted under expedited processing.

a. The criteria for expedited processing include:

1. Satisfaction of all the qualifications to be considered for Medical Staff membership as delineated in these Bylaws, relevant privilege card, the Rules and Regulations and any applicable Hospital and Medical Staff policy or procedure;

2. Proof of acceptable malpractice claims history activity (including past and current malpractice claims, settlements or judgments) in light of the Practitioner's specialty;

3. Demonstration of acceptable practice history (e.g. the Practitioner has not changed practice locations more than three (3) times in the past ten (10) years and has no unexplained gaps in chronological school, training or practice history);

4. Receipt of unanimously favorable peer recommendations;

5. Absence of any disciplinary actions or special conditions during medical school, residency and/or fellowship training;

6. Absence of any investigations, denials, restrictions, lapses, probations, suspensions or limitations on the DEA Certificate or DPS registration;

7. Absence of any investigations, denials, restrictions, lapses, probations, suspensions, licensing board orders, remedial plans or limitations on any current or previous professional license in Texas or in any other jurisdiction;

8. Absence of any probations, withdrawals, special conditions, restrictions, reductions, suspensions, relinquishments, lapses, denials or revocations of Medical Staff membership or clinical privileges by any hospital or health care entity;

9. Absence of any sanctions, exclusions or limitations imposed by any medical organization or professional review organization;

10. No criminal history or felony convictions;

11. No sanctions, exclusions or limitations imposed by any state or federal health care program including Medicare or Medicaid;

12. No sanctions, exclusions or limitations based on quality or patient safety reasons and imposed by any private health care program, including, but not limited to, private third party insurers, health maintenance organizations (HMOs), PHOs, IPAs, etc.;

13. No history of substance abuse or health conditions that may adversely affect the Practitioner's ability to perform clinical privileges requested; and

14. Professional liability insurance in the amounts required by these Bylaws.

b. Following recommendation for approval by the Credentials Committee and the MEC, the Chairperson of the MEC or designee shall make a written recommendation to the Hospital President and the Governing Board Subcommittee assigned the task of reviewing expedited appointments. The Hospital President and the Governing Board Subcommittee shall take action on the application and request for clinical privileges. To the extent membership on the Medical Staff and clinical privileges are so granted, such membership and privileges shall take effect immediately upon the signature of the Governing Board Subcommittee and will be submitted for final approval to the full Governing Board at its next regularly scheduled meeting.

If the Governing Board Subcommittee does not grant Medical Staff membership or clinical privileges, then the application may be resubmitted, and if resubmitted it shall be processed in an unexpedited manner in keeping with these Bylaws. A failure to grant an

expedited appointment shall not entitle the Practitioner to a hearing under these Bylaws.

1.10 Procedure for Reappointment

1.10.1 Term of Reappointment

Reappointment of Members under the age of 70 shall be for a period of no more than two years (24 months). Reappointment of Members age 70 or who will obtain the age of 70 during a reappointment year shall be for a period of no more than twelve months.

1.10.2 Application

a. At least one hundred eighty days (180) prior to the expiration date of a Member's current Medical Staff appointment, a reappointment application shall be sent to the Member. Each Medical Staff Member must submit a completed application at least 90 days prior to such expiration date. An application shall not be considered complete until all requested information has been received.

b. Section 1.8 of these Bylaws shall govern the procedure for handling and approval of an application for reappointment.

c. In addition to the information provided on and with the application for reappointment additional information may be considered, including, but not limited to the following:

1. Number of admissions;

2. Timeliness in completing medical records;

3. Results of quality assurance/performance improvement activities, including drug utilization review, relating to the Member's clinical and/or technical competence using relevant Practitioner-specific data compared to aggregate data, when available and Performance Measurement Data including morbidity and mortality data, when available;

4. Peer recommendations as to the Member's current continuing clinical competence and suitability for continued Medical Staff membership;

5. Fulfillment of Medical Staff responsibilities relating to the Member's category of Staff membership;

1.10.3 Reappointment Application While on Suspension

If a Practitioner is on suspension during the processing of an application for reappointment, the processing of the application shall be tolled until the suspension has ended. If the suspension ends, the Practitioner's privileges shall be extended for a period of time equal to the tolling period, or a decision on reappointment, whichever is sooner. If the suspension is permanent

following a hearing and/or appeal under these bylaws or the Practitioner has waived a hearing or appeal, or has agreed to the permanent suspension, the pending application for reappointment shall be deemed withdrawn. The Practitioner shall not have a right to a hearing with regard to such deemed withdrawal.

1.11 Failure to Submit a Completed Reappointment Application

If the Member does not submit a completed application by 90 days prior to the reappointment expiration date, the application will be deemed incomplete, will not be processed further, and the Member's clinical privileges will expire at the end of the current staff appointment. If privileges expire because of an incomplete reappointment application, the Member is not entitled to a right to a hearing under these Bylaws. Any application submitted less than 90 days prior to the reappointment expiration date shall be processed as a request for an initial appointment.

1.12 Leave of Absence

1.12.1. Leave Status

a. *General.* A Medical Staff member may obtain a voluntary leave of absence (not to exceed the earlier of one [1] year or the last day of the Practitioner's current term of appointment) from the Medical Staff by submitting a written request to the Department Chair or Division Chief or designee and the MEC specifying the reasons and the approximate period of leave. During a leave of absence, the Practitioner shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive. In exceptional circumstances and upon demonstrating good cause, a leave of absence may be extended beyond one (1) year upon approval of the MEC, but not to exceed the current term of appointment.

b. *Military.* A Medical Staff member who is on leave of absence by reason of military deployment may remain on leave of absence until returned from deployment by the military. Such member shall seek reinstatement in keeping with 1.12.2 within six (6) months of being returned from deployment from the military. Medical Staff membership shall be considered abated during any period of deployment outside of the United States and for the first six (6) months after returning from such redeployment.

c. *Investigation while on leave of absence.* If at the time the leave of absence is requested the Practitioner is currently under investigation by a Medical Staff or Hospital committee, such investigation may, within the sole discretion of the investigating committee, be abated until such time as the Practitioner requests reinstatement. If the Practitioner's membership expires while the investigation is abated, the expiration will be considered as a resignation while under investigation and may be reportable to the National Practitioner Data Bank and any appropriate licensing agencies.

d. In the event a Practitioner or authorized representative of a Practitioner is incapable of requesting a leave of absence for reasons of health or other circumstances, the MEC may review same and in its sole discretion place the Practitioner on a leave of absence.

1.12.2. Reinstatement

a. If the leave of absence is for any reason other than the Medical Staff member's illness, incapacity, or impairment or other cause that could affect the Practitioner's ability to fully and competently exercise the clinical privileges granted to such Practitioner, the leave of absence may be terminated prior to its expiration at the written request of the Practitioner, and the Practitioner will be reinstated by the Chairperson of the MEC or designee. To be reinstated, the Practitioner must submit a written request prior to the expiration of the period specified in the Practitioner's request for leave.

b. In circumstances when the leave of absence is due to illness, incapacity, or impairment or other causes that could affect the Practitioner's ability to fully and competently exercise the clinical privileges granted to such Practitioner, reinstatement is conditioned upon a showing that:

1. The Practitioner has submitted to the MEC a written request for reinstatement and demonstrated that the reasons for the leave will no longer exist by the expiration of the leave or by the requested date for reinstatement;

2. In case of impairment, the Practitioner has submitted to the MEC a written request for reinstatement at least thirty (30) days prior to the expiration of the leave. The Practitioner must also present a letter of release from the Practitioner's physician and, as may be required by the MEC or other Medical Staff committee, an agreement for ongoing treatment or therapy, a treatment plan from a treating physician, and the Practitioner's agreement for random testing, if applicable;

3. The Practitioner currently meets all of the qualifications for membership set forth in these Bylaws;

4. The Practitioner currently meets the qualifications for the category of membership to which the Practitioner shall be reinstated; and

5. The Practitioner has submitted such other information as requested by the Credentials Committee, the MEC, or the Governing Board.

c. No reinstatement of a leave granted under (b) above shall be effective until approved by the Governing Board upon the recommendation of the MEC.

d. In the event a Practitioner is incapable of giving notice of reinstatement prior to the expiration of the leave of absence for reasons of health or other circumstances, the MEC may review same and in its sole discretion extend the leave of absence. But in no event may a leave of absence be extended beyond the Practitioner's appointment term.

1.12.3. Failure to Request Reinstatement

Except as noted above, failure to request reinstatement from a leave of absence shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic revocation of Medical Staff membership and clinical privileges. This voluntary resignation does not entitle the Practitioner to the right of a hearing under these Bylaws. A request for Medical Staff membership subsequently received from a Practitioner who fails to request timely reinstatement shall be submitted and processed in the manner specified for applications for initial appointments.

1.13 Resignation

Resignation from the Medical Staff shall be submitted in writing to the chairman of the MEC, and should state the date the resignation becomes effective. Resignation of Medical Staff Membership shall be granted for a Member in good standing provided all incomplete medical records and Medical Staff or Hospital matters have been concluded.

ARTICLE II CLINICAL PRIVILEGES

2.1. Granting of Privileges

2.1.1. Requests

Each application for appointment and reappointment to the following Medical Staff categories must contain a request for the specific clinical privileges desired by the Practitioner:

a. Active

b. Courtesy

c. Consulting

d. Telemedicine

A Medical Staff member may request a modification of clinical privileges at any time by submitting relevant documentation of training and experience, except that such request may not be submitted for at least twelve (12) months after a substantially similar request was denied unless the Medical Staff and Hospital determine in the interim that specialized services that were not initially present now exist.

2.1.2. Basis for Determining Privileges

Requests for clinical privileges shall be evaluated on the basis of the Practitioner's demonstrated ability to exercise such privileges, including but not limited to the following:

a. Relevant education, training, and experience

b. Satisfaction of the minimum eligibility criteria and qualifications described in these Bylaws and the criteria set forth in the Practitioner's privilege cards

c. Documented patient care results, as well as the results of other quality review and monitoring that the Governing Board deem appropriate

d. Clinical performance results obtained from other institutions and health care settings where the Practitioner exercises or has exercised clinical privileges

e. Demonstrated current competence in areas of practice which should include:

- Patient care
- Medical/clinical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

f. Required references

g. The ability to perform the privileges requested and other relevant information.

h. Health status adequate to provide safe patient care

2.1.3 Additional Requirements

In the case of a new Medical Staff appointee or a Member requesting the granting of new clinical privileges, the Medical Executive Committee may recommend conditions that are appropriate to assess and confirm clinical competence. The requested privileges may be granted subject to such conditions (e.g. a period of clinical observation; proctoring; or a period of clinical trial on any or all of the clinical privileges requested). The placing of such restrictions under this section does not entitle the Member to a hearing under these bylaws.

2.1.4 Exercise of Privileges

Except as otherwise provided in these Bylaws, a Member of the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted, consistent with any conditions placed on such practice, and subject to the Rules and Regulations of the Medical Staff and applicable Hospital Rules, Regulations or Policies.

2.1.5 Modification of Clinical Privileges

The Credentials Committee may recommend and initiate a change in the clinical privileges of a Member pursuant to a request under Section 2.1.1. The Credentials Committee may also recommend that the granting of additional clinical privileges to a current Medical Staff Member be made subject to a period of concurrent monitoring. The granting of additional privileges must receive approval from the Board of Managers.

2.2 Lapse of Application

If a Medical Staff Member requesting a change of clinical privileges fails to furnish timely the information necessary to evaluate the request, the request shall be deemed to be voluntarily withdrawn, and the Member shall not be entitled to a hearing under these Bylaws. The deemed withdrawal of the request for new privileges as provided herein will be limited to the new privileges.

2.3 Temporary Clinical Privileges

2.3.1. Circumstances

a. Temporary clinical privileges may be granted to a Practitioner for the care and treatment of specific patients, for the provision of specific procedures, or for a specific period of time where good cause exists, as determined by the Credentials Committee or its designee.

   Good cause includes:

   1. Fulfillment of an urgent patient care, treatment, or service need;

   2. Performance or demonstration of a medical or surgical procedure for educational purposes; or

   3. Provision of consultative services by a nonstaff physician needed because of the physician's clinical expertise or a patient request.

b. Applicants applying for new privileges—which includes an individual applying for clinical privileges at the Hospital for the first time, an individual currently holding clinical privileges who is requesting one or more additional privileges, and an individual who is in the reappointment process and is requesting one or more additional privileges may be granted temporary privileges upon the approval of the Credentials Committee while awaiting review and approval by the Medical Executive Committee (MEC) and Governing Board;

2.3.2. General Conditions

A Practitioner receiving temporary clinical privileges must be appropriately licensed to practice, or if not licensed in the State of Texas must be approved as a visiting physician by the Texas Medical Board, and demonstrate the qualifications, ability, and good judgment necessary to exercise the temporary clinical privileges requested consistent with these Bylaws. The Practitioner shall be bound these Bylaws, Medical Staff Policies, Procedures, Rules and Regulations, and applicable Hospital and department/division policies and procedures. The Practitioner's clinical privileges shall be granted only for the duration of the urgent patient care, treatment, or service need, the patient's stay, the provision of specific procedure(s) for a specified time period, or until fully appointed to the Medical Staff, but in no event shall the grant and exercise of temporary privileges exceed one hundred and twenty (120) days. Such Practitioner shall exercise such privileges only under the supervision of a designated Medical Staff member.

2.3.3. Procedure to Obtain Temporary Clinical Privileges

Requests for temporary clinical privileges shall be submitted in writing to the Chair of the Credentials Committee, as the designee of the Credentials Committee, or Chief Staff as designee of the Medical Executive Committee, who shall evaluate the request and the verification of the information below and recommend whether to approve or deny the request.

a. Current licensure and/or letter of recognition by the Texas Medical Board

b. Relevant training or experience

c. Current competence

d. Ability to perform the privileges requested

e. Other criteria required by the Bylaws, the applicable privilege card, and law

f. A query and evaluation of the National Practitioner Data Bank information

g. Current professional liability insurance in the amounts required by these Bylaws

h. Current valid and unrestricted controlled substance certificate with the Federal Drug Enforcement Administration and registration with the Texas Department of Public Safety, if such are necessary for the clinical privileges for which temporary privileges are sought

i. A complete application

j. No investigations, denials, restrictions, lapses, probations, suspensions, board orders, remedial plans, or limitations on any current or previous professional license in Texas or in any other jurisdiction

k. No probations, involuntary withdrawals, special conditions, restrictions, reductions, suspensions, relinquishments, lapses, denials, or revocations of Medical Staff membership or clinical privileges by any hospital or health care entity

l. No sanctions, exclusions, or limitations imposed by any medical organization or professional review organization

m. No criminal history or felony or misdemeanor convictions (excluding minor traffic violations, but including driving while intoxicated or under the influence)

n. No past or pending sanctions, limitations, or exclusions from participation in any governmental or private third-party agency, insurance program, or reimbursement program, including participation in the Medicare and Medicaid programs

o. No history of drug, alcohol, or substance abuse

The request and the Committee's recommendation shall be forwarded to the Hospital President. The Hospital President shall notify the Practitioner and the Chief of Staff of the determination. If granted, temporary clinical privileges shall take effect immediately and shall be submitted for ratification at the next Governing Board meeting. Denial of such request shall not entitle the Practitioner to a right to a hearing under these Bylaws.

2.3.4. Termination of Temporary Clinical Privileges

Temporary privileges shall expire as specified in Section 2.3.2. Additionally, temporary clinical privileges may be terminated at any time in the following manner:

a. By the Hospital President, upon consultation with the Credentials Committee, MEC, or their designees, or by any person entitled to impose summary suspension pursuant to these Bylaws, upon the discovery of any information or the occurrence of any event that brings into question a Practitioner's qualifications or ability to exercise any or all of the temporary clinical privileges granted; or when in the best interest of patient care a temporary Practitioner's conduct appears to require that immediate action be taken to protect the well-being of any person, including patients, visitors, and Hospital personnel, or to reduce a substantial and imminent likelihood of injury or impairment to the life, health, or safety of any person, including patients, visitors, and Hospital personnel; or

b. By the Governing Board if it does not ratify the granting of temporary privileges.

In such cases the Chief of Staff shall assign a member of the Medical Staff to assume responsibility for the care being provided by such Practitioner. The wishes of the patient shall be considered in selecting a replacement Medical Staff member. A Practitioner whose temporary clinical privileges are terminated shall not be entitled to a right to a hearing under these Bylaws. In the event temporary privileges are terminated under Section 2.3.4.a, the Practitioner shall not be eligible to apply for full or permanent privileges.

2.4 Privileges in Patient Emergencies

In the case of an emergency, any Member of the Medical Staff, within the scope of the Member's license and regardless of staff status, or clinical privileges, is permitted to provide patient care, treatment and service necessary as a life-saving measure or to prevent serious harm to a patient. The Medical Staff Member shall make every reasonable effort to communicate promptly with the patient's attending physician or, if the patient has no attending physician, with the Chief of Staff concerning the need for emergency care and assistance. Once the emergency has passed or other assistance has been made available, the Member shall defer to the patient's attending physician.

2.5 Privileges in Disaster Situations

When the Hospital disaster plan has been implemented and the immediate needs of the patients cannot be met, the Hospital may implement a modified credentialing and privileging process for eligible volunteer Practitioners. The Hospital President, the Chief of Staff, or their respective designees, may grant at their discretion and on a case-by-case basis, temporary emergency disaster privileges to volunteer Practitioners, who are not Members of the Medical Staff and do not have clinical privileges at the Hospital, to address immediate patient care needs in accordance with the emergency management plan. The granting of these privileges shall be based on the needs of the Hospital and its patients and the qualifications of the volunteer Practitioners. The Medical Staff Services office shall be notified as soon as practicable when privileges are granted.

While temporary emergency disaster privileges are granted on a case-by-case basis, volunteer Practitioners considered eligible to act as licensed independent practitioners in the Hospital must at a minimum present a valid government-issued photo identification by a state or federal agency (*e.g.* driver's license or passport) and one of the following:

(a) a current hospital photo identification card that clearly identifies professional designation;

(b) a current license to practice;

(c) primary source verification of the license;

(d) identification indicating that the volunteer Practitioner is a Member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations of groups;

(e) identification indicating that the volunteer Practitioner has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal authority); or

(f) presentation by a current hospital or Medical Staff Member who possesses personal knowledge of the volunteer Practitioner's identity and ability to act as a licensed Practitioner during a disaster.

As soon as practicable, the volunteer Practitioner shall provide information regarding licensure, insurance coverage, and primary hospital affiliation for verification. Refusal to provide such information will disqualify a volunteer Practitioner from eligibility for temporary emergency plan privileges or, if privileges have already been granted, shall result in such privileges being withdrawn and the volunteer Practitioner removed from Hospital premises. In either event the volunteer Practitioner will not be entitled to a right to a hearing under these Bylaws.

The volunteer Practitioner's licensure, liability insurance coverage and continuing current competence shall be verified from primary sources as soon as the immediate situation is under control and within 72 hours from the time the volunteer Practitioner presents to the Hospital. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours, it must completed as soon as practicable and there must be documentation of the following: why primary source verification could not be performed in the required time frame, evidence of a demonstrated ability to continue to provide adequate care, treatment and services, and an attempt to rectify the situation as soon as practicable.

Any volunteer Practitioner granted emergency management plan privileges under the disaster plan must be provided with appropriate identification before exercising temporary emergency disaster plan privileges to permit ready identification. Such volunteer Practitioner may provide patient care only in the designated emergency disaster plan treatment areas, and only under the direct supervision of the chief or alternate chief (or their designees) of the assigned emergency disaster plan treatment area or a designated Medical Staff Member. Upon the discovery of any information or the occurrence of any event that raises questions about the volunteer Practitioner's qualifications or abilities, the supervising chief or alternate chief of the assigned emergency disaster plan treatment area, the President of the Hospital or the Chief of Staff or their designees may terminate the volunteer Practitioner's temporary emergency disaster plan privileges. Temporary emergency disaster plan privileges otherwise will terminate when the emergency disaster plan is no longer activated without any right to a hearing under these Bylaws. Termination of emergency disaster plan privileges, regardless of reason, shall not entitle the Practitioner to a hearing.

2.6 Duties After Appointment

a. By accepting an appointment to the Medical Staff and clinical privileges at the Hospital, the Practitioner shall have the ongoing obligations to notify the Medical Staff Services office in writing no later than five (5) business days upon actual or constructive knowledge of any of the following matters. A failure to do so may be considered equivalent to the submission of false information as defined herein. In the event of such a failure, the MEC may subject the member to such actions as it deems appropriate, including but not limited to revocation of membership with no right to reapply for membership at any time in the future. An affected member shall not be entitled to a hearing in such instance.

The Practitioner is to provide notification of any material change to information submitted as part of an initial or renewal application for Medical Staff membership, including all information required by these Bylaws, including but not limited to:

1. An arrest or criminal charges filed against the Practitioner

2. The filing of a professional liability case against the Practitioner

3. A complaint filed with the Texas Medical Board resulting in an official/jurisdictional investigation

4. Orders (whether agreed or otherwise) and/or remedial plans by any state licensing authority by which the Practitioner is licensed to practice

5. No longer being certified as a diplomat or a registered active candidate in good standing in the process toward certification by the applicable specialty board

6. Being diagnosed with or treated for drug, alcohol, or substance abuse or chemical dependency or receiving treatment for a mental, physical, or emotional condition that may affect patient safety or interfere with the Practitioner's ability to safely exercise clinical privileges

7. Being placed on a clinical, behavior, monitoring, rehabilitation, or other type of contract, agreement, or understanding (whether in writing or not, whether disciplinary in nature or not) related to alcohol, drug, or substance abuse or behavior, mental, emotional, clinical, or physical issues.

8. Any requested or mandatory leave of absence by the Practitioner at any health care facility.

9. The cessation of medical practice by the Practitioner at any health care facility for any reason (except for a voluntary resignation while not under investigation for a period exceeding thirty [30] days).

10. The reduction of the Practitioner's professional liability insurance coverage below the minimum limits set forth in these Bylaws, or exclusion from coverage for any procedures for which the Practitioner has or is seeking clinical privileges.

b. Provide and/or secure continuous care of the Practitioner's patients and seek consultation whenever necessary or appropriate.

c. Maintain an ethical practice, including refraining from the following: offering, soliciting, providing, or accepting illegal inducements for patient referrals; allowing patient care services to be provided by a physician-in-training without the direct supervision of the

responsible attending physician; and delegating patient care responsibility to nonqualified or inadequately supervised providers.

d. Document a medical history and physical examination (H&P) for all patients within twenty-four (24) hours of admission, prior to surgery, or prior to any procedure requiring anesthesia services. H&Ps performed in a Practitioner's office may be accepted if the H&P was performed within thirty (30) days prior to admission or surgery and was reviewed and updated—with documentation attesting that the H&P was reviewed, the patient was examined, and that "no change" occurred in the patient's condition since the H&P was completed—within twenty-four (24) hours of admission. H&Ps completed prior to thirty (30) days or H&Ps not properly updated will not be accepted.

1. A Dentist can perform an H&P relevant to the body systems specific to their privileges. For additional information relevant to complete the H&P, a Physician (MD or DO) must be consulted.

2. Additional requirements contained in the H&P are set forth in the Rules and Regulations.

e. Maintain continued compliance with the Hospital's vaccination policy.

f. Maintain on file with the Medical Staff Services office a current cell phone number and a current e-mail address.

g. Maintain competency in the Hospital's electronic health record system.

h. Undergo alcohol, drug, and substance testing as determined by the MEC in its sole discretion.

i. Maintain continued compliance with the Medical Staff and Hospital Codes of Conduct and all applicable policies, procedures, rules, and regulations.

2.7 Categories of the Medical Staff

The Medical Staff appointment categories shall include Active, Courtesy and Consulting.

a. The Governing Board and the MEC may choose not to offer every category to every specialty as they determine will best serve and fulfill the Hospital's mission.

b. The MEC has the authority to review the activity levels (i.e., number of contacts) and make the appropriate category assignment or reassignment of its Practitioners at any time.

2.7.1 Active Staff

a. Qualifications

1. A Member of the Medical Staff whose primary practice is not office based is eligible for the category of Active staff by maintaining a minimum of 24 or more patient encounters each year of each appointment period.

2. A Member of the Medical Staff whose primary practice is office based and who does not perform procedures at the Hospital is eligible for the category of Active staff as follows:

   (i) Is a Member of the staff of another medical facility or organization at which the Member actively participates in quality review, evaluation and monitoring activities similar to those required of the Active staff of this Hospital; and

   (ii) Agrees to provide requested quality data from the facilities or organization at which Member has membership

b. Prerogatives

A Member of the Active staff may:

1. Admit patients without limitation, subject to these Bylaws, the Rules and Regulations and applicable Hospital rules, regulations and policies;

2. Exercise such clinical privileges as are granted pursuant to these Bylaws;

3. Vote on all matters presented at general and special meetings of the Medical Staff and committees of which the Practitioner is a Member; and

4. Hold any office that is voted on by all Members of the Medical Staff and committees of which Practitioner is a Member.

c Responsibilities

In additional to other obligations contained in these Bylaws as well as Medical Staff Rules and Regulations and Hospital Policies and Procedures, a Member of the Active Staff shall:

1. Participate in the emergency services call program as determined by the Member's specialty or the MEC;

2. Actively participate in the quality evaluation and monitoring activities required of Medical Staff Members;

3. Discharge the basic responsibilities set forth in these Bylaws, Rules and Regulations and applicable Hospital Rules, Regulations and Policies;

4. Retain responsibility within the Member's area of professional competence for the continuous care and supervision of each patient for whom the Member is responsible for providing services in the Hospital, or arrange a suitable alternative in accordance with these Bylaws, Rules and Regulations and applicable Hospital Rules, Regulations and Policies;

5. Have procedures in place to provide care to or assist in the provision of care to such Member's patients who come or are brought to the hospital's emergency room;

6. Report any changes in health status to the Credentials Committee immediately; and

7. Discharge such other staff functions as may be required from time to time by the MEC or the Chief of Staff.

8. When there is a bed shortage, regardless of the reason, active staff members will be granted priority over the members of all other medical staff categories for elective admissions subject to the needs of the patient in each case.

2.7.2 Courtesy Staff

a. Qualifications

A Member of the Medical Staff is eligible for the category of Courtesy staff as follows:

1. Maintain at least six (6) and up to a maximum of 23 encounters at the hospital each year of each appointment period. This maximum number shall not include patient encounters that occurred when the Courtesy Staff Member is providing call coverage for an Active staff Member. An Courtesy Staff Member will not be required to become an Active staff Member because of call-coverage encounters alone; and

2. Is a Member of the active staff of another hospital where the Member actively participates in quality review, evaluation and monitoring activities similar to those required of the Active staff at this Hospital.

3. If a Courtesy Staff Member participates in more than 23 patient encounters per year, the Medical Executive Committee will make an evaluation at the end of the appointment period, or at anytime when it is determined that the Courtesy Staff Member's activity has significantly increased to determine if reassignment to the Active staff category is warranted. If a Courtesy Staff Member fails to provide any patient encounters during an appointment period, the MEC will consider such lack of activity as a voluntary resignation of medical staff membership and clinical privileges.

b. Prerogatives

A Courtesy Staff Member may:

1. Admit patients to the hospital subject to these Bylaws, within the limitations provided in the Rules and Regulations and applicable Hospital rules, regulations and policies and under the same conditions as specified for Active Staff Members;

2. Exercise such clinical privileges as are granted to the Member;

3. Not hold any office that is voted on by all Members of the Medical Staff.

c. Responsibilities

In additional to other obligations contained in these Bylaws as well as Medical Staff Rules and Regulations and Hospital Policies and Procedures, a Member of the Courtesy staff shall:

1. Participate in the emergency services call program as determined by the MEC;

2. Actively participate in the quality evaluation and monitoring activities required of Medical Staff Members;

3. Discharge the basic responsibilities set forth in these Bylaws and Rules and Regulations and applicable Hospital policies and procedures;

4. Retain responsibility within the practitioner's area of professional competence for the continuous care and supervision of each patient for whom the Member is responsible for providing services in the Hospital, or arrange a suitable alternative in accordance with these Bylaws, Rules and Regulations and applicable Hospital Rules, Regulations and Policies;

5. Have procedures in place to provide care to or assist in the provision of care to such Member's patients who come or are brought to the hospital's emergency room;

6. Report any changes in health status to the Credentials Committee immediately; and

7. Discharge such other staff functions as may be required from time to time by the MEC.

2.7.3 Consulting Staff.

a. *Requirements for Consulting Staff*. The Consulting Staff shall consist of physicians eligible for Staff membership who may treat the patients of Members of the Active or

Courtesy Medical Staff for short periods of time, including nights and weekends. Consulting Staff shall make application and be appointed as all other Staff Members.

b. *Prerogatives of Consulting Staff*. Consulting Staff may not admit patients. Consulting staff may consult, write orders, and treat only patients for whom consultations are requested. Consulting medical staff members are required to practice with another fully privileged member of the medical staff. They cannot vote or hold office in this medical staff organization, but they may serve on committees with or without a vote, at the discretion of the Chairman of the Committee. Consulting Medical staff members may attend general staff meetings, including open committee meetings and educational programs. Consulting staff do not have a minimum encounter requirement.

c. *Obligations of Consulting Staff:* Each Member of the Consulting Staff shall discharge the basic obligations of Staff Members as required in the Bylaws and Rules and Regulations and applicable Hospital Policies and Procedures; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; and perform such further duties as may be required of him/her under these Bylaws or Hospital or the MEC.

2.8 Telemedicine Staff

a. *Qualifications*. The Telemedicine Staff category shall consist of medical staff members who are physically located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, consultation, or treatment that requires the use of advanced telecommunications technology. A member of the Telemedicine Staff may be either an in-state provider or an out-of-state provider and must satisfy all requirement of the Texas Medical Board for the practice of telemedicine, including licensure requirements.

b. *Responsibilities*. A member of the Telemedicine Staff shall:

1. Actively participate in the quality evaluation and monitoring activities required of Medical Staff members;

2. Discharge the responsibilities set forth in these Bylaws, Medical Staff Policies, Procedures, Rules and Regulations, and applicable Hospital and department/division policies and procedures;

3. Retain responsibility within his area of professional competence for the continuous care and supervision of each patient for whom he is responsible for providing services, or arrange a suitable alternative as applicable in accordance with these Bylaws, Medical Staff Policies, Procedures, Rules and Regulations, and applicable Hospital and department/division policies and procedures;

4. Report any changes in health status as outlined in Section 2.8.a to the MEC immediately;

5. Discharge such other staff functions as may be required from time to time by the MEC or the Chair of the Department in which the member is assigned;

6. Is not required to participate in the emergency services call program;

7. May not hold a Medical Staff leadership position; and

8. Shall not admit patients to the Hospital.

c. *Limitations*:

1. An out-of-state telemedicine licensee's clinical practice shall be limited exclusively to the interpretation of diagnostic testing and reporting results to a physician fully licensed and located in Texas or for the follow-up of patients where the majority of patient care was rendered in another state, and the license holder shall practice medicine in a manner so as to comply with all other statutes and laws governing the practice of medicine in the state of Texas.

2. Unless a person holds a current full license to practice medicine in Texas, a person holding an out-of-state telemedicine license shall not be authorized to physically practice medicine in the state of Texas.

ARTICLE III CORRECTIVE ACTION

3.1 Actions Other Than Summary Restriction or Suspension

3.1.1 Basis for Corrective Action

An evaluation of a Member of the Medical Staff may be instigated whenever information indicates that the Member may have exhibited acts, demeanor, or conduct which may (1) be detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) be unethical; (3) be contrary to these Bylaws, Medical Staff Rules and Regulations, or any Hospital Rules, Regulations and policies; (4) be below applicable professional standards; or (5) indicate impairment due to substance abuse, a medical or psychological health condition. The Chief of Staff, any member of the medical staff, the Hospital President or the Board of Managers may request an evaluation of such member.

3.1.2. Initial Evaluation

Evaluations shall be conducted by a Medical Staff committee or an ad hoc committee appointed by the MEC to conduct such evaluations or by representatives of such committees. Practitioners and others who are not members of the Medical Staff may be invited to participate in any such evaluations. If as a result of the evaluation there is a recommendation for opening an investigation, such recommendation shall be given to the MEC. The initial evaluation shall not

constitute a "hearing," and the member shall not be entitled to a hearing under these Bylaws. All evaluations under this Article 3 shall be part of the medical committee process.

3.1.3. Investigation

Investigations shall be conducted by a Medical Staff committee or an ad hoc committee appointed by the MEC to conduct such investigation or by representatives of such committees. Practitioners and others who are not members of the Medical Staff may be invited to participate in any such investigations. If as a result of the investigation there is a recommendation for action, such recommendation shall be given to the MEC. The investigation shall not constitute a "hearing," and the member shall not be entitled to a hearing under these Bylaws. All investigations under this Article 3 shall be part of the medical committee process.

3.1.4. MEC Action

Upon the conclusion of the investigation, the MEC may, in its sole discretion, take action and/or make recommendations that may include but are not limited to the following:

a. Removal of any adverse information from the member's file if no corrective action is warranted by the investigation;

b. Deferral of action;

c. Issuance of letters of admonition, censure, reprimand, or warning. The affected member may respond to such letters and warnings, and any written responses shall be placed in the member's file;

d. Imposition of special conditions that may include, but are not limited to, case review, continuing medical education, counseling, or probation, which do not involve a restriction, reduction, suspension, or revocation of Medical Staff membership or the member's ability to exercise clinical privileges;

e. Restrictions on continued Medical Staff membership or exercise of clinical privileges that may include co-admissions, mandatory consultation, proctoring, or case supervision;

f. Reduction, suspension, or revocation of clinical privileges;

g. Suspension, revocation, or probation of Medical Staff membership; or

h. Other actions deemed appropriate in the sole discretion of the MEC under the circumstances.

3.1.5. Subsequent Action

a. Any MEC recommendation or action that does not give the Practitioner a right to a hearing under these Bylaws may be implemented by the MEC without further review and shall be effective at the date and time determined by the MEC.

b. The MEC shall notify the Board of Managers and the affected member of any recommendation or action that gives the Practitioner a right to a hearing under these Bylaws.

3.1.6. Initiation by Board of Managers

The Governing Board in its discretion may direct the MEC to initiate an investigation or to consider such actions as it may deem appropriate. If the MEC fails to act, the Board of Managers may initiate actions consistent with these Bylaws.

3.2 Summary Restriction or Suspension

3.2.1 Criteria for Initiation

A summary restriction or suspension of Medical Staff membership or clinical privileges may be imposed;

a. whenever a Member's conduct appears to require that immediate action be taken to protect the well-being of any person including patients, visitors, and Hospital personnel, or

b. to reduce a substantial and imminent likelihood of injury or impairment to the life, health, or safety of any person including patients, visitors, and Hospital personnel.

Unless otherwise indicated by the terms of the summary restriction or suspension, the affected Member's patients shall be assigned to another Medical Staff Member in accordance with these Bylaws, the Rules and Regulations, Hospital Policies and Procedures.

3.2.2. Initiation of Summary Restriction or Suspension

A summary suspension may be initiated by the Chairperson of the MEC, the Chief Medical Officer/Vice President of Medical Affairs, or the appropriate Department Chair. If neither the Chairperson of the MEC, Chief Medical Officer/Vice President of Medical Affairs, nor the appropriate Department Chair is available, the Hospital President or the Governing Board may summarily restrict or suspend a Practitioner's Medical Staff membership or clinical privileges.

3.2.3. Notice of Summary Restriction or Suspension

Written notice of the summary restriction or suspension shall be given to the Practitioner. The MEC, the Hospital President, and the Board of Managers shall be informed of the action taken.

3.2.4. Duration of Summary Restriction or Suspension

Unless otherwise stated, such summary restriction or suspension shall be effective immediately upon imposition. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if not stated, until resolved as set forth herein.

3.2.5. MEC Action

No later than fourteen (14) days after the initiation of a summary restriction or suspension, the MEC shall review and consider the action. The affected Practitioner may request to present a statement to the MEC in writing or in person, and that request may be granted or denied by the MEC in its sole discretion; however, the Practitioner may not be represented by an attorney at any meeting, and any meeting shall not be considered a hearing under these Bylaws. The MEC may conduct whatever review or investigation it deems appropriate. At the conclusion of the review and/or investigation, the MEC shall determine whether to modify, continue, or terminate the summary restriction or suspension and shall deliver notice of its determination to the affected Practitioner and shall inform the Board.

If the MEC does not ratify the restriction or suspension, it shall terminate upon the earlier of (a) the end of the fourteenth (14th) day after imposition or (b) the date the MEC votes not to ratify the action.

3.2.6. Procedural Rights

If the summary restriction or suspension is not terminated by the end of the fourteenth (14th) day, the affected Practitioner shall be entitled to a hearing under these Bylaws.

3.3 Administrative Suspension and Revocation

An administrative suspension of Medical Staff membership or clinical privileges may be made by the MEC based on a Practitioner's conduct as described in this Section 3.3. Unless otherwise stated, an automatic administrative suspension as described herein shall be effective immediately upon the first business day following the date of delinquency or expiration or upon imposition in all other cases**.** The MEC shall deliver written notice to the affected Practitioner and shall inform the Chief of Staff, the Hospital President, and the Board of Managers. The administrative suspension shall remain in effect for the period stated or, if not stated, until resolved as set forth herein. The Practitioner shall have no right to a hearing for an administrative suspension.

3.3.1. Licensure

If a Practitioner's license to practice medicine, dentistry, or podiatry in Texas lapses, the Practitioner's clinical privileges shall be automatically suspended until the deficiency is corrected. If, within thirty (30) days following the lapse, the Practitioner does not demonstrate that his license to practice in Texas has been renewed, the Practitioner shall be deemed to have voluntarily resigned Medical Staff membership and clinical privileges due to ineligibility.

If a Practitioner's license to practice in Texas is restricted, reduced, suspended, revoked, or placed on probation, the member's Medical Staff membership and clinical privileges shall be subject to the same action under the same terms and conditions as of the date such action becomes effective and throughout its term.

The Practitioner shall not be entitled to a hearing under this section.

3.3.2. DEA Certificate and DPS Registration

Unless the requirements have been waived by the MEC, if a Practitioner's Federal Drug Enforcement Administration (DEA) certificate or Texas Department of Public Safety (DPS) registration lapses, the Practitioner's clinical privileges may be suspended unless the Practitioner provides documentation from the DEA or DPS demonstrating that the expiration date of the DEA certificate or DPS registration has been extended, or the Practitioner agrees in writing to refrain from issuing any orders or prescriptions covered by such certificate or registration. The Practitioner shall have fourteen (14) days following the lapse to demonstrate that his DEA certificate or DPS registration has been renewed. If not renewed within this fourteen (14) day period, the Practitioner may request from the MEC an extension of time of not more than an additional fourteen (14) days to demonstrate renewal. The MEC may grant or deny an extension in its sole discretion. Absent a request for an extension, the Practitioner's Medical Staff membership and clinical privileges shall automatically be deemed voluntarily resigned at the end of the initial fourteen (14) day period due to ineligibility for membership. If at the end of any extension the Practitioner cannot demonstrate renewal, the Practitioner's Medical Staff membership and clinical privileges shall be considered voluntarily resigned due to ineligibility.

If a Practitioner's DEA certificate or DPS registration is suspended or revoked, the Practitioner shall be administratively suspended until such time as it is reinstated. If not reinstated at the end of the Practitioner's current appointment period, the Practitioner shall not be qualified for reappointment. Any application for appointment thereafter will be processed as an initial appointment.

If a Practitioner's DEA certificate or DPS registration is placed on probation, restricted, or reduced, the member's clinical privileges shall be subject to the same action under the same terms and conditions as of the date such action becomes effective and throughout its term.

The Practitioner shall not be entitled to a hearing under this section.

3.3.3. Professional Liability Insurance

If a member fails to maintain professional liability insurance as set forth in these Bylaws, the Practitioner's clinical privileges shall be automatically suspended until the deficiency is corrected. If within ninety (90) days following the deficiency, the Practitioner does not provide evidence of required professional liability coverage, the Practitioner shall be deemed to have voluntarily resigned due to ineligibility for membership. The Practitioner shall not be entitled to a hearing under this section.

3.3.4. Medical Records

If a member fails to complete and sign medical records in accordance with Medical Staff Rules and Regulations and policies and procedures, the member's clinical privileges may be suspended as described in the Medical Staff Rules and Regulations until the deficiency is corrected. The Practitioner shall not be entitled to a hearing under this section.

3.3.5. Failure to Respond to Request for Information

A member of the Medical Staff shall respond in writing to any requests for information from the Hospital, any Hospital committee, the MEC, any Medical Staff committee, the Chief of Staff, the Board of Managers, or any of their designees. The response shall be made within ten (10) days of the date of the request or any other date specified. If a member fails to respond or provide the requested information in a timely manner, the member's clinical privileges may be suspended for a period of time up to fourteen (14) days as determined by the MEC in its sole discretion. The failure to provide a timely response shall not, in and of itself, delay any action that might be taken with regard to the subject matter of the request for information. The Practitioner shall not be entitled to a hearing under this section.

3.3.6. Failure to Appear

A Practitioner shall appear at any department, division, or committee meeting at which the Practitioner has been requested to attend. Failure to appear without good cause or a failure to participate in good faith at the meeting may result in a suspension of any such portion of privileges as the MEC specifies, for a period of time up to fourteen (14) days as determined by the MEC in its sole discretion. The failure to appear as required shall not, in and of itself, delay any action that might be taken with regard to the subject matter of the required appearance. The Practitioner shall not be entitled to a hearing under this section.

3.3.7. Behavior, Conduct, and Practice

A member of the Medical Staff shall adhere to these Bylaws, the Medical Staff's and Hospital's Code of Conduct, policies, procedures, rules and regulations, departmental/division policies and procedures, the ethics of the profession, and the member's specific discipline, shall work cooperatively with others, and shall discharge properly the responsibilities of the Medical Staff, which include an obligation to act within the standard of care. If a member fails to do so, or if a

member's behavior or actions undermine the reasonably expected functioning of the Medical Staff or the Hospital, the member's clinical privileges may be suspended for a period of time up to fourteen (14) days as determined by the MEC in its sole discretion. The Practitioner shall not be entitled to a hearing under this section.

3.3.8. Obligation to Undergo Examination and Testing

A member shall undergo physical and/or mental examinations and related testing when so instructed by the Chief of Staff, MEC, Practitioner Behavior and Health Committee, or the Board of Managers or when required by Medical Staff rules, regulations, or policies and procedures or Hospital policies or procedures. . Such testing may include drug, alcohol, or substance abuse testing. Such examination and/or testing shall take place at such time and place as specified and shall be at the member's expense. A failure to comply with such instructions may result in an administrative suspension for a period of time up to fourteen (14) days as determined by the MEC in its sole discretion. A failure to undergo drug, alcohol, or substance abuse testing in accordance with Medical Staff or Hospital policy or as otherwise instructed shall be deemed to be a positive test. The Practitioner shall not be entitled to a hearing under this section.

3.3.9. Proximity to Hospital

Practitioners shall maintain a professional office or personal residence in reasonable proximity to the Hospital as necessary for the Practitioner's clinical duties unless such is not required on the Practitioner's applicable privilege card. A failure to do so may result in a deemed voluntary withdrawal of privileges due to membership ineligibility.

The Practitioner shall not be entitled to a hearing under this section.

3.3.10. Falsification of Application

If a Practitioner has falsified an application for appointment or reappointment, the Practitioner's Medical Staff membership and clinical privileges may be suspended. If upon investigation such falsification is confirmed, the MEC may declare an automatic revocation and the Practitioner shall not be entitled to a right to a hearing under these Bylaws.

3.3.11. Repetitious Infractions

If a member has been subject to at least three (3) administrative suspensions under this Section 3.3 within a consecutive twenty-four (24) month period, the Practitioner's Medical Staff membership and clinical privileges may be revoked by the MEC. The Practitioner shall not be entitled to a hearing under this section.

3.3.12. Felony

If a Practitioner is convicted of a felony, the Practitioner's Medical Staff membership and clinical privileges shall be automatically revoked upon the Hospital receiving notice of the

conviction. Such revocation shall be effective immediately upon the conviction without regard to any right of appeal of the conviction the member may have. The Practitioner shall not be entitled to a hearing under this section.

3.3.13. Violation of Practitioner Agreement

If a Practitioner violates the terms of a fitness for duty agreement and/or substance abuse agreement, the Practitioner's Medical Staff membership and clinical privileges may be revoked by the MEC in its sole discretion. The Practitioner shall not have a right to a hearing under this section.

3.3.14 .Revocation Under Agreement

In the event that a Practitioner is under an agreement (practice, behavior, substance, or otherwise) with a Medical Staff committee or the Board of Managers, which by its terms provides for the loss of clinical privileges and Medical Staff membership without a hearing under these Bylaws, and the Practitioner loses clinical privileges and Medical Staff membership under the agreement, the Practitioner shall be disqualified from Medical Staff membership or reapplication at any time in the future. The Practitioner shall not be entitled to a hearing under this section.

3.3.15. Sanctions and Exclusions by State or Federal Programs

If a Practitioner is excluded by any state or federal health care program, including Medicare, Medicaid, and/or Tricare, the Practitioner's clinical privileges shall be automatically suspended and Medical Staff membership shall be considered voluntarily resigned as of the date such exclusion becomes effective. If a Practitioner is sanctioned or has a limitation imposed by any state or federal health care program including Medicare, Medicaid, and/or Tricare, the Practitioner's clinical privileges may be suspended by the MEC for as long as such sanction or limitation exists. The Practitioner shall not be entitled to a hearing under this section.

3.4 Professional Health

Whenever the Practitioner's behavior, actions, demeanor, conduct, or physical or mental condition appears to be inappropriate, dysfunctional, or impaired, the Practitioner will be referred to the Physician Assistance Committee and may be asked by the Chief of Staff, Hospital President, Credentials Committee, MEC, Physician Assistance Committee, or the Board of Managers to provide evidence of current health status through a physical or mental examination. An impairment due to physical or mental impairment or drug, alcohol, or substance abuse may be grounds for immediate summary suspension of the Practitioner's clinical privileges as provided in these Bylaws.

A Practitioner has an affirmative duty to self-report to the Chief of Staff, Hospital President, MEC, Physician Assistance Committee or Board of Managers any health matter that may adversely affect the Practitioner's ability to safely exercise clinical privileges. A failure to self-report may result in corrective action as provided herein.

Management and resolution of professional health matters shall be the responsibility of the Physician Assistance Committee, which shall report to the MEC.

A Practitioner may seek assistance from the Physician Assistance Committee at any time.

Any physical or mental examination and drug, alcohol, or drug testing or screening shall be at the expense of the affected Practitioner and shall be performed by persons or entities approved by the Physician Assistance Committee or the MEC.

ARTICLE IVHEARING AND APPEAL PROCEDURE

4.1 Grounds for Hearing

a. This section describes the exclusive circumstances that entitle a Practitioner to a right to a hearing. A Practitioner shall be entitled to a hearing only upon making a timely request for a hearing after any of the following actions:

1. A Medical Executive Committee (MEC) recommendation to deny an application, under Section 1.8 or Section 1.10., for reasons other than failure to meet qualification/eligibility requirements or for reasons under Section 1.8.2.

2. A MEC action longer than fourteen (14) days that is a reduction, suspension, or revocation of clinical privileges or Medical Staff membership (other than an administrative action or pursuant to an agreement with the Practitioner).

3. Any MEC recommendation for a reduction, suspension, or revocation of clinical privileges or Medical Staff membership that lasts longer than 14 days (other than an administrative suspension or pursuant to an agreement with the Practitioner).

4. A decision by the Board of Managers to not ratify an initial appointment or reappointment.

b. A Practitioner does not have a right to a hearing or an appeal for circumstances or actions of any kind not expressly set forth in Section 4.1.a.

c. A hearing shall be conducted in accordance with the provisions of these Bylaws.

4.2 Notice to Practitioner of Action

4.2.1. Notice

a. When an action occurs that entitles a Practitioner to a hearing, notice shall be given to the affected Practitioner that shall include:

1. A statement of the action or recommendation and fair notice of reasons for it;

2. A statement that the Practitioner has the right to request a hearing within 30 days of delivery of this notice;

3. A statement that the Practitioner may affirmatively waive the right to a hearing, and that the failure to submit a timely request for a hearing shall be deemed a waiver of the right to a hearing and acceptance of the final action; and

4. A summary of the rights in the hearing as provided in these Bylaws, including the Practitioner's right to be represented by an attorney of the Practitioner's choice and at the Practitioner's sole expense.

b. Notice shall be deemed delivered when (1) sent by certified mail, return receipt requested, to the Practitioner's professional office or personal residence, or (2) hand-delivered to the Practitioner or designee personally.

4.2.2. Request for Hearing

The Practitioner has 30 days following the date of delivery of such notice to submit a written request for a hearing to the Hospital President or Chief of Staff. Failure to timely request a hearing shall be deemed a waiver of all rights to a hearing under these Bylaws and acceptance of the action or recommended action, as applicable.

4.3 Practitioner's Request for Mediation

When a Practitioner is entitled to a hearing, the Practitioner may require the MEC to participate in mediation. The Practitioner must request mediation in writing to the Hospital President Chief of Staff within ten (10) business days of delivery of notice of the right to a hearing. The mediation must be scheduled and completed as soon as practicable, and in no event shall mediation be held less than fourteen (14) days before the hearing is scheduled (if a hearing has been timely requested) unless the Practitioner and MEC otherwise agree in writing. The parties shall be required to share the cost of any mediation equally. The mediator shall be qualified according to state law and selected by the MEC.

4.4 Timing and Notice of Hearing

The hearing shall take place as soon as practicable but no sooner than thirty (30) days after the notice of hearing unless an earlier hearing date has been agreed to in writing by the parties. The notice shall include:

a. A proposed list of witnesses, as known at the time, but which may be modified as changes are known, who may give testimony or evidence on behalf of the MEC action or recommendation; and

b. A concise statement of the reasons for the action or recommendation as well as the list of records and documents that may be used in support of the action or recommendation.

This statement, and list of records and documents, may be revised, supplemented, or amended as necessary prior to the hearing.

4.5 The Hearing

4.5.1. Composition of the Hearing Panel

a. The MEC shall appoint a Hearing Panel composed of either one (1) or more practitioners, as the MEC in its sole discretion determines appropriate. A practitioner member of the Hearing Panel must not have been in direct economic competition with the Practitioner at any time during the previous twelve (12) months, and must not have been a member of any committee that previously considered or acted upon the issue that is the subject matter of the hearing. A practitioner is not disqualified from serving on the Hearing Panel by having previously considered matters related to the Practitioner that are not the subject of the hearing.

b. Practitioner members of the Hearing Panel need not be members of the Hospital's Medical Staff, nor are they required to have training or expertise in the same clinical practice area as the Practitioner.

c. Practitioner members of the Hearing Panel may be compensated for reasonable time in preparing for and conducting the hearing. If compensation is proposed, the MEC shall deliver notice to the Practitioner of the proposed compensation and the opportunity for the Practitioner to pay one-half of such compensation.

4.5.2. Presiding Officer

a. The MEC may appoint an attorney as Presiding Officer. General Counsel to the Hospital may not serve in this capacity. The Presiding Officer may not act as prosecuting officer or as an advocate for either side at the hearing. The Presiding Officer shall:

1. Afford all participants in the hearing a reasonable opportunity to be heard and to present oral and documentary evidence, subject to reasonable limits on the nature and extent of the proposed evidence;

2. Determine the number of witnesses and duration of direct and cross-examination as the Presiding Officer deems necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

3. Prohibit conduct or presentation of evidence that is cumulative, excessive, abusive, irrelevant, or that causes undue delay;

4. Maintain decorum throughout the hearing;

5. Facilitate delivery of relevant information to the Hearing Panel;

6. Have the authority and discretion to rule on all questions pertaining to procedural matters and admissibility of evidence, including the exclusion of witnesses from the hearing room during testimony of other witnesses or exclusion of any evidence; and

7. Conduct sidebar conferences with counsel and hear arguments by counsel on procedural points outside the presence of the Hearing Panel unless the Hearing Panel wishes to be present.

The Presiding Officer may participate as a legal advisor in the private deliberations of the Hearing Panel, but the Presiding Officer shall not be entitled to vote on the recommendations of the Hearing Panel. The Presiding Officer may thereafter continue to advise the Governing Board on the matter.

b. If no Presiding Officer has been appointed, the Chairperson of the Hearing Panel shall be the Presiding Officer and shall be entitled to one (1) vote.

c. The Presiding Officer may be compensated for reasonable time in preparing for and conducting the hearing. If compensation is proposed, the MEC shall deliver notice to the Practitioner of the proposed compensation and the opportunity for the Practitioner to pay one-half of such compensation.

4.5.3. Representation by Counsel

The Practitioner shall be entitled to representation by an attorney or other person of the Practitioner's choice and at the Practitioner's sole expense. The Practitioner shall notify the Hospital President or the Chief of Staff in writing of the name and all contact information of the attorney or representative at least twenty-one (21) days before the date of the hearing. The MEC shall appoint a person, who may be an attorney, as its counsel. The Hospital President, representatives from the MEC and Hospital Administration may attend the hearing to observe and to testify; however, no other individuals may attend the hearing.

4.5.4. Discovery

a. There is no right to conduct discovery in connection with the hearing. However, the Practitioner shall be entitled to request the following information, subject to a stipulation signed by both parties that such information shall be maintained as confidential and shall not be disclosed or used for any purpose outside the hearing:

1. Copies of, or reasonable access to, all patient medical records referred to as a basis for the adverse recommendation, at the Practitioner's expense;

2. Reports of experts relied upon by the Credentials Committee, MEC, or Governing Board; and
3. Copies of any other documents relied upon in reaching the action taken or recommended.

b. At a mutually agreed time prior to the hearing or as provided by the Presiding Officer, each party shall provide the other party with a list of proposed exhibits and witnesses. If the Practitioner intends to rely upon expert testimony, a written report from each such expert shall be provided at the same time as the list of exhibits and witnesses. All objections to documents or witnesses (to the extent then reasonably known) shall be submitted prior to the hearing to the Presiding Officer for consideration and ruling.

c. Neither the Practitioner nor the Practitioner's representative shall contact directly or indirectly Hospital employees or, Medical Staff or Hospital committee members appearing on the MEC's witness list concerning the subject matter of the hearing, unless agreed upon by counsel.

4.5.5. Prehearing Conference

The Presiding Officer may require counsel for the parties to participate in a prehearing conference. The Presiding Officer may issue any rulings he deems appropriate for the orderly conduct of the hearing, including:

a. *List of witnesses*. Each party shall provide a written list of the names and addresses of the witnesses expected to offer testimony and a short summary of the expected testimony. Failure to do so may be grounds for the Presiding Officer to refuse testimony from such witnesses at the hearing. Either party may, in the discretion of the Presiding Officer, supplement or amend the witness list before the hearing provided that notice is given to the other party. The Presiding Officer has the authority to limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative.

b. *Time for presentation*. The time available for each party's presentation of testimony and evidence and cross-examination shall be determined by the Presiding Officer.

c. *Documentary evidence*. All documentary evidence must be exchanged on or before the prehearing conference. Any objections shall be made at that time and ruled upon by the Presiding Officer. Failure to disclose and provide such documentary evidence may be grounds for the Presiding Officer to exclude such evidence.

4.5.6. Rights of Both Parties

Both parties shall have the following rights, subject to reasonable limits determined by the Presiding Officer: to call and examine witnesses, to introduce exhibits, to cross-examine any witness, and to submit a closing statement including points of argument and citation of authorities at the end of the hearing. If the Practitioner does not testify on his behalf, the Practitioner may be called adversely and examined as if under cross-examination.

At the hearing, the MEC shall proceed first. The Practitioner shall have the right to proceed following the conclusion of the presentation of the MEC. The MEC shall have the right to rebuttal after the presentation of the Practitioner.

4.5.7. Admissibility of Evidence

Formal rules of evidence and procedure shall not be strictly enforced. However, the Presiding Officer shall make rulings for the orderly conduct of the hearing. Any relevant noncumulative evidence shall be admitted if a reasonable person would rely on such evidence in the conduct of serious affairs, regardless of its admissibility in a court of law. The Hearing Panel may question the Practitioner and other witnesses, call additional witnesses, and request additional documentary evidence.

4.5.8. Taking Official Notice of Matters

The Hearing Panel has the discretion to take official notice of any matter that was not submitted by the parties but which the Hearing Panel deems relevant to the issues under consideration. The parties shall be informed of the matters to be officially noticed, and such matters shall be noted in the hearing record or panel report. Either party shall have the opportunity to object and refute that a matter be officially noticed. Reasonable additional time shall be granted, if requested, to present written rebuttal to any evidence admitted by official notice.

4.5.9. Burden of Proof and Basis of Decision

The MEC shall not have any burden of proof regarding the action or proposed recommendation. The burden of proof shall rest solely on the Practitioner to prove by a standard of "clear and convincing evidence" (as routinely defined in law) that the action or recommendation, in light of the MEC recommendation, was either (1) arbitrary and capricious, or (2) not supported by substantial evidence. "Arbitrary and capricious" means the absence of any rational connection between the known facts and the recommendation made. "Not supported by substantial evidence" means that no reasonable person could conclude that there was sufficient support for the recommendation based on the facts.

The Hearing Panel shall recommend in favor of the MEC recommendation unless the Practitioner has carried the burden of proof as to each one of the Practitioner's contentions.

4.5.10. Record of Hearing

A stenographic reporter shall make a record of the hearing. The cost of such record shall be borne by the Hospital, but copies of the record may be provided to the Practitioner at his expense. Each witness shall testify only on oath or affirmation administered by the Presiding Officer, and all testimony shall be contained in the record.

4.5.11. Adjournment and Conclusion

The Presiding Officer may adjourn and reconvene the hearing for the convenience of the participants without special notice. The hearing shall conclude when the Presiding Officer, after consultation with the Hearing Panel, finds that no more evidence needs to be presented or questions need to be asked.

4.5.12. Postponements and Extensions

Requests for postponements or extensions of the hearing shall be permitted by mutual agreement, or by the Presiding Officer on a showing of good cause.

4.5.13. Failure to Appear

Failure, without good cause, of the Practitioner to appear timely and proceed at the hearing shall be deemed a waiver of the hearing and a voluntary acceptance of the action or recommendation.

4.5.14. Deliberations and Recommendation of the Hearing Panel

Within twenty (20) days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer and shall render a recommendation, in the form of a written report, which shall contain concise statements of the reasons for the recommendation.

4.5.15. Delivery of Hearing Panel Report

The Hearing Panel shall deliver its recommendation and report to the Hospital President and Chief of Staff who shall forward it, along with the record, to the Board of Managers for further action. A copy of the recommendation and report shall be forwarded to the Practitioner.

4.5.16. Board of Managers Action

No later than the next regularly scheduled meeting following receipt of the Hearing Panel's recommendation, the Board of Managers shall review such recommendation and the earlier MEC action or recommendation. The Board of Managers may appoint a subcommittee of Board members to review the matter and bring a recommendation to the Board within ninety (90) days of receipt of the Hearing Panel's recommendation. The Board is not bound by the recommendation of the Hearing Panel, so it may affirm, reverse, or modify its recommendation. The Board shall notify the Practitioner of its decision, with a statement of the basis for the decision, within ten (10) days of its decision in writing by personal delivery to the Practitioner or designee or by certified mail, return receipt requested.

4.6 Appellate Review

4.6.1. Request for Appeal

Within fourteen (14) days after receiving notice of the action of the Governing Board, the Practitioner may request an appeal. This request shall be made in writing, certified mail, return receipt requested, to the Hospital President or Chief of Staff and shall specify the reasons justifying further review. Failure to make a timely request shall constitute a waiver of the right of appeal and an acceptance of the Board's ruling.

4.6.2. Grounds for Appeal

The grounds to be argued on appeal shall be limited to:

a. Substantial and material failure to comply with this article of the Bylaws so as to deny a fair hearing; or

b. A Board action under Section 4.5.16, in light of the recommendation of the Hearing Panel, that was (1) arbitrary and capricious, or (2) not supported by substantial evidence (as defined above).

4.6.3. Notice of Review

Unless otherwise agreed by the parties, the review shall be held within forty-five (45) days of the receipt of a timely request for appeal. The Practitioner shall receive written notice, return receipt requested, of the date, time, and place for the review no later than fourteen (14) days prior to the scheduled appellate review. The time for review may be extended for good cause by the Chairperson of the Board.

4.6.4. Composition of the Appellate Review Committee

The Chairperson of the Board shall appoint a committee to act as an appellate body with one (1) member being designated as Chairperson. The Review Committee shall consist of not less than five (5) members and shall not contain any person who directly participated in the hearing. The Review Committee shall contain three (3) members of the Board and two (2) members of the Medical Staff. These Medical Staff members shall not be members of the Credentials Committee or the MEC, or in direct economic competition with the Practitioner. The Hospital President, and representatives of the MEC and Hospital Administration may attend the proceedings, but not as voting members of the Review Committee.

4.6.5. Presiding Officer

The Chairperson of the Review Committee may appoint a Presiding Officer to assist in matters of argument and procedure during the review process. The Presiding Officer may be, but is not required to be, the same individual who served in that capacity during the hearing.

4.6.6. Written Statement

Each party shall have the right to present a written statement in support of its position on appeal. Legal counsel may assist in the preparation of these statements. The written statement shall be delivered to the Chairperson of the Review Committee and the other party at least seven (7) days before the date of the scheduled review. Each party shall have three (3) days to submit written objections to the form and/or content of the other party's statement to the Chairperson of the Review Committee. The Chairperson, who may consult with the Presiding Officer if one is appointed, shall rule on these objections.

4.6.7. Record on Appeal

Except as provided below, the record on appeal that may be reviewed and considered by the Review Committee shall be limited to (1) the written statements; (2) the evidence admitted in the hearing consisting of (a) documents, (b) witness testimony, and (c) matters taken by official notice; (3) the record of the hearing; and (4) closing statements submitted at the end of the hearing. New evidence shall be accepted at the sole discretion of the Review Committee and only upon a sufficient demonstration by the proponent that the new evidence was not reasonably available at the time of the hearing.

The Review Committee has sole discretion whether to allow the parties and their counsel to appear in person to present oral arguments subject to any limitations imposed by the Review Committee.

4.6.8. Recommendation to the Board

The Review Committee shall review the record on appeal and statements of the parties, and shall deliberate in private. The Review Committee may adjourn and reconvene at any time if additional investigation or deliberation is needed.

The Review Committee may recommend that the Board affirm, reverse, or modify the previous decision. The decision of the Review Committee shall be by majority vote of its members and shall be communicated in writing to the Board within ten (10) days after conclusion of the appellate review.

4.6.9. Board Action

The Governing Board shall review the recommendation of the Review Committee and make its final decision not later than its next regularly scheduled meeting. The Board is not bound by the recommendation of the Review Committee, so it may affirm, reverse, or modify same. If the Board requests further investigation, such investigation shall take place and be reported to the Board within thirty (30) days, and final action shall be taken not later than the next regularly scheduled meeting after such report. The Board decision shall be communicated in writing to the MEC and the Practitioner.

4.7 Right to One Hearing and One Appeal

The Practitioner shall have the right to only one (1) hearing and one (1) appellate review on any matter.

ARTICLE V CONFIDENTIALITY, IMMUNITY AND RELEASE

5.1 Confidentiality of Information

5.1.1 General

Confidentiality shall be accorded to the fullest extent permitted by law to all activities of the Medical Staff that occur pursuant to the Bylaws and the Medical Staff Policies, Procedures, Rules and Regulations.

5.1.2 Breach of Confidentiality

Any breach of the confidentiality is outside appropriate standards of conduct of this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate, and such conduct shall be considered in the granting or removal of clinical privileges or prerogatives of Medical Staff membership. Any action taken shall be considered administrative in nature and shall not entitle the Member to a hearing.

5.2 Immunity from Liability

5.2.1 For Action Taken

Each representative of the Medical Staff, Hospital and Board of Managers shall be exempt, to the fullest extent permitted by law, from liability to a Practitioner or Member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff, Hospital or Board of Managers.

5.2.2 From Providing Information

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to a Practitioner or Member for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, a Practitioner or Member of the Medical Staff or who did, or does, exercise clinical privileges or provides services at this Hospital.

5.3 Activities and Information Covered

The confidentiality and immunity provided by this Article shall apply to all acts, communications, investigations, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

a. application for appointment, reappointment, or clinical privileges;

b. corrective action;

c. hearings and appellate reviews;

d. utilization reviews;

e. other department, division, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

f. peer review activities.

5.4 Release

Each Practitioner or Member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

ARTICLE VICOMMITTEES OF THE MEDICAL STAFF

6.1 Committees

Other than the MEC, Medical Staff committees shall be defined in Medical Staff Policies and Procedures and/or the Medical Staff Rules and Regulations and include, but are not limited to, general meetings of the Medical Staff as a committee of the whole; meetings of departments, divisions, or sections; meetings of standing committees established under the Rules and Regulations or Policies and Procedures; and meetings of special or ad hoc committees created to perform specified tasks. Each Medical Staff committee shall have the authority to appoint subcommittees and special or ad hoc committees as needed and shall be accountable to the MEC.

Each Medical Staff Committee acts as either a "medical peer review committee" or a "medical committee" pursuant to Texas law, including Texas Occupations Code Sections 151.002(a)(7), 151.002(a)(8), and 160.007 and the Texas Health and Safety Code Section 161.031 *et seq.* or their successors. Accordingly, all activities, proceedings, documents, reports, information, records and all communications of any Medical Staff committee, whether a medical peer review committee or a medical committee. are privileged and confidential to the fullest extent permitted by law.

6.2 Medical Executive Committee.

The Medical Executive Committee is a standing committee of the Medical Staff and is empowered to act for the medical staff as a whole in the intervals between full Medical Staff meetings. The Medical Executive Committee shall have Members, who are physicians, dentists, and/or podiatrists who have been appointed to the Medical Staff and are in good standing. It shall be composed of at least 6 members which shall include the Chief of Staff, Vice-Chief of Staff, Secretary-Treasurer, Chairs of the Quality Review, Surgical, Utilization Review, Quality, Environment of Care, and Infection Control and a Member at Large who shall be elected by the

Medical Staff. The Hospital President shall be an ex-officio non-voting member and shall not count in the quorum. Other administrative ex-officio members may include the Chief Nursing Officer and Director of Quality Management. The Chief of Staff shall be Chair of the MEC. All Medical Directors will have a standing invitation to attend, but shall not have any voting rights.

The nomination and election of the Member at Large shall be in the same manner as the nomination of election of Officers of the Medical Staff.

The roster of nominees shall be submitted to the Medical Staff for review and vote by means of ballots, which may be delivered to members of the Medical Staff by hand, fax, mail, or electronically. The ballots must be returned by the date specified on the ballot, which shall not be less than two (2) weeks from the date the ballot is sent. The person receiving the highest number of votes shall be deemed the Member at Large.

The Nominating committee shall meet at least 30 days before the election of officers shall take place. It shall nominate at least one and no more than three members for each officer position.

No member of the Organized Medical Staff is ineligible for election to the Medical Executive Committee solely because of his/her professional discipline, specialty, or practice as a hospital-based physician.

6.2.1 Duties and Authority of the Medical Executive Committee:

a. Act on all matters on behalf of the self-governing, organized Medical Staff, without requirement of subsequent approval by the Medical Staff, subject to any limitations imposed by these Bylaws;

b. Receive, coordinate and act upon, as necessary, reports and recommendations of Medical Staff departments and committees and Make recommendations to the governing board;

c. Coordinate, or oversee coordination of, the activities of and policies adopted by the staff, Medical Staff departments, and other committees;

d. Implement policies and procedures of the Medical Staff, and Hospital as applicable;

e. Inform the Medical Staff on accreditation programs and the accreditation status of the Hospital and be responsible for maintaining the standards recommended by CMS and other accrediting bodies;

f. Recommend directly to the Board of Managers on the following matters: the process to review credentials and delineate privileges at appointment, reappointment, and at the time of a request for an increase in privileges; category assignments; membership criteria; the delineation of privileges through the medical staff process; clinical privileges including a request for evaluation when there is doubt about an applicant's ability to perform the privileges requested; and, the medical staff structure.

g. Recommend performance improvement activities to include but not be limited to: medical assessment and treatment of patients; use of medications; use of blood products and components; use of operative and other procedures; efficiency of clinical practice patterns; any significant departures from established patterns of clinical practice; activities related to patient safety; and, analyzing and improving patient satisfaction;

h. Ensure medical staff and others with delineated clinical privileges participate in continuing medical education and Hospital sponsored education activities. These activities shall relate in part to the type and nature of care offered by the Hospital and the findings of performance improvement activities;

i. Make recommendations to the President of the Hospital on medico-administrative, hospital management, and planning matters.

j. Act on behalf of the organized Medical Staff between Medical Staff meetings.

k. On an annual basis determine whether sufficient space, equipment, staffing and financial resources are in place and/or available to support all privileges requested and granted.

6.2.2 Resignation/Removal from Medical Executive Committee:

Any Medical Executive Committee member may resign at any time by giving written notice to the Chair of the MEC. Such resignation takes effect on the date of receipt, or at the time specified in the resignation. Removal of a Medical Executive Committee member may be effected by the Board of Managers, by a two-thirds (2/3) vote of members of the MEC, or a majority vote of the active staff appointees present at a regularly scheduled Medical Staff meeting or a called meeting for that purpose. Grounds for removal shall be the same grounds as those for Medical Staff Officers, defined in Section 7.7 of these Bylaws.

6.2.3 Meetings and Reporting:

The Medical Executive Committee will meet a minimum of six (6) times annually and will communicate actions taken to the Board of Managers and when appropriate to the medical staff as a whole.

6.2.4 Executive Session of the MEC

An executive session if closed to nonmembers of the MEC with the exception of individuals invited to attend by the Chair of the MEC.

ARTICLE VII OFFICERS

7.1 Listing.

Officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Secretary-Treasurer, and Immediate Past Chief of Staff. Current officers of the Medical Staff are listed in Addendum

A. Addendum A is subject to modification as provided in these Bylaws and such modifications do not qualify as amendments to the Bylaws.

7.2 Qualifications.

Each officer shall:

7.2.1 Be a member of the active staff at the time of nomination and election, have no circumstance that prohibits him/her from practicing at the Hospital and remain a member in good standing during his/her term of office.

7.2.2 Have demonstrated executive and administrative ability through experience and participation in staff activities.

7.2.3 Be Board Certified in his/her specialty and recognized for a high level of clinical competence.

7.2.4 Have demonstrated a high degree of interest in and support of the Medical Staff and Hospital.

7.2.5 Agree to, and if elected, willingly and faithfully discharge the duties and exercise the authority of the office held and work with the other officers and committees, the President of the Hospital, and the Board of Managers.

7.2.6 Be approved by the Board of Managers.

7.3 Term of Office.

7.3.1 There shall be no limitation on the number of times a Member may be an officer of the Medical staff, but in no event shall a Member have more than 3 consecutive terms in any given office.

7.3.2 The term of office of staff officers is three (3) years beginning January 1 and ending December 31, except that an officer elected or appointed to fill a vacancy assumes office immediately upon election or appointment. Each officer serves until the end of his/her term and/or until a successor is elected, unless he/she sooner resigns or is removed from office.

7.4 Attainment of Office.

7.4.1 Chief of Staff:

The Chief of Staff shall be elected for a three (3) year term by the active staff members. The term of office shall begin the first day of January following the election.

7.4.2 Vice Chief of Staff:

The term of office shall begin the first day of January following the election.

7.4.3 Secretary-Treasurer:

The Secretary-Treasurer shall be elected for a three (3) year term by the active staff members. The term of office shall be the first day of January following the election.

7.4.4 Immediate Past- Chief of Staff:

The Immediate Past- Chief of Staff attains office by automatic succession from the office of Chief of Staff.

7.4.5 Election:

The election of officers shall take place no later than the First of December in an election year. Voting shall be by secret written ballot. Authenticated and sealed ballots delivered via hand or via mail may be counted. Written ballots shall include handwritten signatures for comparison with signatures on file when necessary. Voting by proxy will not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate receives a majority vote, a runoff election between the two candidates receiving the highest number of votes shall be held at the meeting by secret written ballot. If a tie results, the majority vote of the Medical Executive Committee shall decide the election. The votes of the Medical Executive Committee members shall be by secret written ballot at its next meeting or a special meeting called for that purpose. The election shall become effective when approved by the Board of Managers.

7.5 Vacancies in Office.

7.5.1 Chief of Staff:

A vacancy in the office of President is filled by the Vice Chief of Staff who may serve out the remaining term. If the Vice Chief of Staff chooses to serve for the remaining term of the Chief of Staff, thereby leaving a vacancy in the office of Vice Chief the vacancy will be filled by the MEC.

7.5.2 Vice Chief of Staff

A vacancy in the office of the Vice Chief of Staff is filled by appointment of an acting officer by the Medical Executive Committee, subject to approval by the Board of Managers. The acting officer will serve out the remaining term.

7.5.3 Immediate Past Chief of Staff:

A vacancy in the office of Immediate Past Chief of Staff is filled for the remainder of the unexpired term by appointment by the Medical Executive Committee. Consideration should be given in filling the vacancy to prior Chiefs of Staff.

7.6 Resignation from Office.

Any officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation takes effect on the date of receipt or at the time specified in the resignation.

7.7 Removal from Office.

7.7.1 Process:

Removal of an Officer may be effected by the Board of Managers or a majority vote by secret ballot of the active staff appointees in good standing and present at a special meeting called for that purpose. This ballot must be ratified by the Board of Managers. The officer who is the subject of removal shall be given ten (10) days prior written notice of the meeting at which the vote on removal is to be taken and shall be afforded the opportunity to speaking on his/her own behalf before the Medical Staff or Board of Managers, as applicable, prior to taking any vote on his/her removal.

7.7.2 Grounds for Removal:

(a) Failure to perform the duties of the position held in a timely and appropriate manner.

(b) Failure to continuously satisfy the qualifications for the position.

(c) Having an automatic or summary suspension (other than for delinquent medical records) imposed by operation of these Bylaws or a corrective action matter of these Bylaws resulting in a final decision other than to take no action.

(d) Conduct or statement damaging to the best interests of the Medical Staff or the Hospital, their goals, programs, or public image.

(e) Physical or mental infirmity that renders the officer incapable of fulfilling the duties of office.

7.8 Duties of Officers.

7.8.1 Chief of Staff:

The Chief of Staff is the primary officer and the medical staff's representative in the relationships to others within the Hospital. The Chief of Staff shall serve as the Chief Administrative Officer of the Medical Staff and shall have responsibility for supervision of the general affairs of the Medical Staff. The responsibilities, duties and authority of the Chief of Staff include:

(a) Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff;

(b) Serve as Chairperson and as a voting member of the Medical Executive Committee and call, preside at, and be responsible for the agenda of all meetings thereof;

(d) Appoint and discharge the Chairpersons and members of all standing Medical Staff Committees, except when these memberships are designated by these Bylaws or by specific direction of the Board;

(e) Be responsible for enforcement of Medical Staff Bylaws, the Rules, and Regulations and all other applicable Policies and Procedures, implement sanctions when indicated, and enforce the Medical Staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner or other individual with clinical privileges;

(f) Be accountable and responsible to the Board for the quality and efficiency of clinical services and professional performance of the Medical Staff in the provision of patient care;

(g) Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the President and the Board of Managers;

(h) Receive and interpret the opinions, policies, and directives of the Administration and the Board to the Medical Staff;

(i) Act as the representative of the Medical Staff to the public as well as to other health care providers, other organizations, and regulatory or accrediting agencies in external professional and public relations; and

(j) Perform all other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, the Medical Executive Committee, or by the Board of Managers.

7.8.2 Vice Chief of Staff:

Whenever the Chief of Staff is unable, temporarily or permanently, to fulfill the duties of office by reason of illness, resignation, removal or other absence, the Vice Chief of Staff will succeed to the office of Chief of Staff. When the Chief of Staff is absent from a meeting for whatever reason, the Vice Chief of Staff will be empowered to act in the stead of the Chief of Staff. He/she will also be responsible for other duties delegated by the Chief of Staff or by the Medical Executive Committee. He/she is a voting member of the Medical Executive Committee.

7.8.3 Immediate Past Chief of Staff :

The Immediate Past Chief of Staff will be an advisor to the Chief of Staff and to other officials and committees of the staff and shall serve as a voting member of the Medical Executive Committee. The Immediate Past Chief of Staff shall perform other duties as requested by the Chief of Staff.

7.8.4 Secretary-Treasurer:

Whenever the Vice Chief of Staff is unable, temporarily or permanently, to fulfill the duties of office by reason of illness, resignation, removal or other absence, the Secretary-Treasurer will succeed to the office of Vice Chief of Staff. This officer shall serve as a voting member of the Medical Executive Committee, and shall have custody of all funds of the Medical Staff, make accounting to the Medical Executive Committee and to the Medical Staff at its regular meetings. The duties of the Secretary-Treasurer are to:

(a) Maintain a roster of Medical Staff members;

(b) Keep accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings;

(c) Assure that all notices of Medical Staff meetings are given as provided in these Bylaws, on order of the Chief of Staff; and,

(d) Maintain a record of Medical Staff dues, collections, and accounts, and sign checks for the Medical Staff fund expenditures pursuant to his/her authority.

ARTICLE VIII MEETINGS

8.1 Annual Meeting.

The General Staff Meeting of the Medical Staff shall be held annually as determined by the Medical Executive Committee. At this meeting, committees shall make such reports as may be desirable. Officers for the ensuing three (3) years may be elected at the General Staff meeting unless a vacancy occurs, in which case a special election shall be held in accordance with the

Medical Staff Bylaws Article 7.5. A quorum is considered to be a majority the eligible members present.

8.2 Special Meetings.

Special meetings of the Medical Staff may be called at the request of the Board of Managers, Medical Executive Committee, or ten (10) members of the active staff. The agenda at special meetings will be as follows: 1) Reading of the notice calling the meeting; 2) transaction of business for which the meeting was called; and 3) adjournment.

ARTICLE IX ADOPTION AND AMENDMENT OF BYLAWS, RULES AND REGULATONS

9.1 Medical Staff Authority

The Medical Staff has the ability to adopt and amend Bylaws, Rules and Regulations, and policies and procedures and to propose them directly to the Board of Managers.

9.2 Procedure for Bylaws

Any Bylaws or proposed amendment(s) to the Bylaws shall be submitted to the Medical Staff for review and vote by means of ballots, which may be delivered to members of the Medical Staff by hand, fax, mail, or electronically. The ballots must be returned by the date specified on the ballot, which shall not be less than two (2) weeks from the date the ballot is sent. During the voting period, the proposed Bylaws and amendment(s) shall be available for inspection in the Medical Staff Services office. The Bylaws or amendment(s) shall be adopted upon a majority vote in favor of same. A failure to return a ballot within the specified time shall be deemed an acceptance of the Bylaws or proposed amendment(s) and shall be counted as a favorable vote in determining the number of votes for or against the proposed Bylaws or amendment(s).

9.3 Governing Board Action

The Bylaws and any amendment to the Bylaws, which have been adopted by the Medical Staff shall become effective upon ratification by the Board of Managers. The Board of Managers shall take action on any Bylaws or amendment at its next regularly scheduled meeting following receipt from the Medical Staff.

9.4 Initiation of Amendment by Board of Managers

The Governing Body may in its sole discretion, when it determines it is in the best interest of patient care or effective operation of the Hospital, submit directly to the Medical Staff proposed amendments to these Bylaws.

9.5 Rules and Regulations and Medical Staff Policies

9.5.1. Delegation

Subject to approval by the Board of Managers, the Medical Staff delegates to the Medical Executive Committee (MEC) the authority to adopt or amend Medical Staff rules, regulations, and policies and procedures.

9.5.2. Medical Staff Rules and Regulations

Subject to approval by the Board of Managers, the MEC shall adopt Rules and Regulations to implement more specifically the general principles found in these Bylaws. These Rules and Regulations govern the conduct of Medical Staff organizational and administrative activities and the level of practice required of each Practitioner at the Hospital. If the MEC proposes to adopt or amend a rule or regulation, it shall first communicate the proposal to the Medical Staff. Rules and regulations may be adopted, amended, or repealed at any regular or special meeting of the MEC with the approval of at least two-thirds (2/3) of the MEC members present and eligible to vote and without prior notice. Such amendments shall become effective when approved by the Board of Managers.

9.5.3. Medical Staff Policies and Procedures

Medical Staff policies and Procedures. The MEC may adopt or amend Medical Staff policies and procedures for the conduct of the affairs of the Medical Staff. Such policies and procedures shall be consistent with these Bylaws, Rules and Regulations of the Medical Staff, and applicable Hospital policies and procedures. Policies and procedures may be adopted, amended, or repealed at any regular or special meeting of the MEC with the approval of at least two-thirds (2/3) of the MEC members present and eligible to vote and without prior notice. All policies adopted or amended shall be communicated to the Medical Staff.

9.5.4. Maintenance of Rules, Regulations, Policies and Procedures

All Medical Staff Rules and Regulations and all Medical Staff, policies and procedures shall be maintained by the Medical Staff Services office.

9.6 Savings Clause

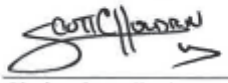
The provisions set forth in these Bylaws supersede all prior versions thereof. Except as expressly superseded herein, the provisions of the existing Rules and Regulations and other applicable Hospital policies and procedures shall remain in full force and effect unless and until replaced by a subsequently written document. To the extent the existing Policies, Procedures, Rules and Regulations or other applicable Hospital policies and procedures conflict with the provisions set forth herein, the provisions of these Bylaws shall control.

9.7 Conflict Management

In the event of a conflict between the MEC and the Medical Staff as presented by a written petition signed by at least 20% of the voting members of the Medical Staff, regarding a proposed

rule or adopted rule or policy, or other issue of significance to the Medical Staff, the Chief of Staff of the Medical Staff shall convene a meeting of the petitioner's representative(s). The written Petition of Conflict shall include a designation of up to five members of the voting Medical Staff who shall serve as the Petitioner's representative(s). The MEC shall be represented by equal number of MEC Members. The representatives of the MEC and the Petitioner shall exchange information relative to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the MEC, the safety and quality of patient care at the hospital and applicable laws, rules and regulations. Resolution requires a majority vote of the representatives of the MEC at the meeting and a majority vote of the representatives of the Petitioners at the meeting. In the event that the differences are not resolved, it shall be submitted to the Board of Managers for consideration and making its final decision with respect to the proposed rule, policy or issue.

Adopted: _____
Date March 19, 2018

Approved: 
Chair of Medical Executive Committee

Approved: 
Chair of Board of Managers

ADDENDUM A